1990

AARP INFORMATION
RESOURCE CENTER, NRTA

The Medicare Handbook

Including Information for Beneficiaries on:

- *Medicare Benefits*
- *Participating Physicians and Suppliers*
- *Health Insurance to Supplement Medicare*
- *Limits to Medicare Coverage*

1990

PUBS
RA
412
.3
Y68
1990

#4

Medicare Catastrophic Coverage Act Repealed

The Medicare Catastrophic Coverage Act of 1988 has been repealed, and, with it, certain expandedbenefits that were explained in the 1989 Medicare Handbook.* The extra charges to pay for catastrophic benefits have also been cancelled.

As a result of the repeal, your benefits for hospital, skilled nursing facility and hospice services under Medicare hospital insurance (Part A) are different from those that were available in 1989. In general, your 1990 benefits will be the same as those that were available to you in 1988. For example:

—For hospital services, payment is based on benefit periods, and you may have to pay more than one hospital deductible in a year. You also may have to pay coinsurance for a lengthy hospital stay.

—Skilled nursing facility services are available only after a hospital stay. There also are other changes in the skilled nursing facility benefit.

—The number of covered days available for hospice services is limited to 210.

Medicare catastrophic benefits scheduled to be available in 1990 and 1991 (the limit on out-of-pocket expenses under Part B and the expanded prescription drug benefit under Part B, for example) have been cancelled.

This 1990 Medicare Handbook describes Medicare benefits available and premium, deductible, and coinsurance amounts you will have to pay this year.

* Except for beneficiaries enrolled in certain prepaid health plans (see page 3)

Many doctors and suppliers have agreed to be part of Medicare's participating physician and supplier program. They accept assignment on all Medicare claims. If you get your medical services from one of these participating doctors or suppliers, you can often save time and money. See page 16 for more information about the assignment method of payment, and what you can do to find a participating doctor or supplier.

This handbook is meant to explain the Medicare program but is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations and rulings.

RA
412.3
.Y68
1990
c.4

[illegible]

MEDICARE READY REFERENCE, 1990

MEDICARE HOSPITAL INSURANCE, PART A, 1990

Covered Service	You Pay* Deductible	You Pay* Coinsurance
Inpatient Hospital Care: (see page 6)		
Limited medically necessary care.**	$592 deductible for first 60 days of each benefit period plus cost of first three pints of blood used per year--unless you have paid for or replaced blood under Medicare medical insurance (Part B).	$148 per day for 61st through 90th day each benefit period. $296 per day for each reserve day used (Only 60 reserve days per lifetime).
Inpatient Skilled Nursing Facility Care: (see page 8)		
100 days of post-hospital care per benefit period.	No deductible.	No coinsurance for first 20 days. $74 each day for 21st through 100th day each benefit period.
Home Health Care: (see page 9)		
Limited medically necessary skilled care if you are confined in your home.	No deductible.	No coinsurance except for durable medical equipment. You pay 20 percent of the approved amount for durable medical equipment.
Hospice Care: (see page 10)		
Up to 210 days of care if certified by a physician as terminally ill and you elect hospice benefit.	No deductible.	5 percent of cost of outpatient drugs or $5 toward each prescription, whichever is less. 5 percent of allowable daily rate for respite care.

Medicare Hospital Insurance Premiums

- No monthly premium under Medicare Part A for most beneficiaries, but:
  — those who buy Medicare Part A pay a $175 per month Part A premium, and
  — the premium may be higher for those who enroll late.

*Medicare beneficiaries enrolled in prepaid health care organizations such as Health Maintenance Organizations (HMOs), pay Medicare coinsurance and deductible amounts to the organizations in the form of premiums, copayments, or other charges. These organizations may not charge Medicare beneficiaries, on average, more than they would have paid under regular fee-for-service Medicare for Medicare-covered services.

**Hospital insurance will help pay for no more than 190 days of inpatient care in a participating psychiatric hospital in your lifetime.

MEDICARE MEDICAL INSURANCE, PART B, 1990

Part B Deductible, Coinsurance and Premiums

Deductibles: The standard Part B deductible is $75.

—The deductible applies to most, but not all, Part B services.

—When you have paid $75 for covered services in 1990, you will have met your Part B deductible for the whole year.

The Part B blood deductible

—In addition to the standard Part B deductible, you must pay for or replace the first three pints you use each year—unless you paid a blood deductible under Part A.

Coinsurance: For most services you receive under Part B, you will be required to pay a 20 percent coinsurance amount.

Premiums: Most beneficiaries enrolled in Part B pay $28.60 per month, but

—Some beneficiaries pay an additional amount due to late enrollment in Medicare Part B.

Payment by Assignment

For certain Part B services the physician/provider/supplier must take assignment. In other cases the physician/provider/supplier may choose to take assignment on some or all of your charges.

(See page 16 for an explanation of assignment.)

—On an assigned claim, the physician/provider/supplier agrees to accept the Medicare-approved amount as full payment, and you are responsible only for any unmet deductible and coinsurance amounts.

—On an unassigned claim, you must pay any unmet deductible and coinsurance amounts, plus charges above the Medicare-approved amount in most cases.

Part B Services for 1990*

All Part B services subject to $75 deductible and 20 percent coinsurance unless noted in handbook.

Professionals and organizations providing the following services submit their claims directly to Medicare for payment. You are responsible only for any required deductible and coinsurance amounts.

- Ambulatory surgical center services
- Certified registered nurse anesthetist services
- Clinical diagnostic laboratory tests (no deductible or coinsurance)
- Comprehensive outpatient rehabilitation facility services
- Home health services (no deductible or coinsurance)
- Nurse midwife services
- Outpatient hospital services
  - Incident to services of physician
  - Diagnostic tests
  - Partial hospitalization psychiatric programs
- Outpatient physical therapy, occupational therapy, and speech pathology furnished by provider organizations
- Physician assistants and services incident to their services
- Psychologists services and services incident to their services
- Rural health clinic services

Most professionals and organizations that furnish the following items or services have the option, but are not required, to take assignment. (For services you get before September 1, 1990, you may have to submit the bill to Medicare yourself. For services you get on or after September 1, 1990, the professional or organization must submit the bill to Medicare for you, whether under assignment or not.)

- Ambulance services
- Antigens and blood clotting factors
- Artificial limbs and eyes
- Diagnostic X-ray tests and other diagnostic tests
- Drugs used in immunosuppressive therapy
- Durable medical equipment
- Hepatitis B vaccine
- Limb, back, or neck braces
- Physical and occupational therapists' services when in independent practice
- Physician services and services incident to physician services
- Pneumococcal vaccine (no deductible or coinsurance)
- Prosthetic devices
- Radiation therapy
- Surgical dressings, splints, casts

*Medicare medical insurance covers services and supplies for treatment of kidney disease. Those services are described in Medicare Coverage of Kidney Dialysis and Kidney Transplant Services: A Supplement to Your Medicare Handbook. You can get this booklet from Social Security or the Consumer Information Center (see inside back cover).

CONTENTS

GENERAL INFORMATION ABOUT MEDICARE

What is Medicare? 1
Beneficiary Complaints 2
Prepaid Health Care Organizations 3
Your Medicare Card 4
Buying Health Insurance to Supplement Medicare 4
Fraud and Abuse Hot Line 5
Financial Assistance for Low-Income Beneficiaries 5

HOSPITAL INSURANCE

Prospective Payment System 5
Medicare Hospital Insurance 5
When You Are A Hospital Inpatient 6
Skilled Nursing Facility Care 8
Home Health Care 9
Hospice Care 10

MEDICAL INSURANCE

Deductible and Coinsurance Amounts 11
Covered Doctors' Services 12
Second Opinion Before Surgery 13
Services of Special Practitioners 13
Outpatient Hospital Services 13
Other Covered Services and Supplies 14
Drugs and Biologicals 16
Assignment 16
Participating Doctors and Suppliers 17
Participating Providers 17
Explanation of Medicare Benefits Notice 17
Approved or "Reasonable" Charges 18
Medicare Payments for Outpatient Treatment of Mental Illness 18

YOUR RIGHT OF APPEAL

Appealing Decisions by Providers of Hospital Insurance Services 19
Appealing Decisions by Peer Review Organizations (PROs) 19
Appealing Decisions by Intermediaries on Hospital Insurance Claims 19
Appealing Decisions by Carriers on Medical Insurance Claims 19
Appealing Decisions by Health Maintenance Organizations (HMOs or Competitive Medical Plans (CMPs) 20

WHAT MEDICARE DOES NOT PAY FOR

Care That is Custodial 20
Care Not Reasonable And Necessary Under Medicare Program Standards 20
Services Medicare Does not Pay For 20
Limit of Beneficiary Liability 20

GETTING THE PART OF MEDICARE YOU DO NOT HAVE

Getting Medicare Medical Insurance 21
Getting Medicare Hospital Insurance 21
Special Enrollment Period 21

EVENTS THAT CAN CHANGE YOUR MEDICARE PROTECTION

When Protection Ends for Persons 65 and Older 22
When Protection Ends for the Disabled 22
When Protection Ends for those with Kidney Failure 22

HOW TO SUBMIT MEDICAL INSURANCE CLAIMS

A New Rule 22
Submitting Your Medical Insurance Claim 23
When Other Insurance Pays First 23
Submitting Claims For a Person Who Dies 24
Time Limits 25
Where To Send Your Claims 25

OTHER IMPORTANT INFORMATION

Form 1490S 26
An Important Message From Medicare 28
Medicare Carriers 30
Medicare Peer Review Organizations and Quality Review Organizations 35
Glossary 39

ABOUT THIS HANDBOOK

Your Medicare handbook is designed to help you determine if Medicare pays for the services you need and how payments are made. It is intended to be a handy reference to help you understand how the Medicare program works and to know what your benefits are. While Medicare pays for many of your health care expenses, it does not cover all of them. Therefore, it is important for you to know in advance what Medicare does and does not pay for.

Handbook Highlights

- Page 23 tells you how to submit your Medicare medical insurance claims.
- Beginning on page 30, there is an address list showing you where to send your medical insurance claims.
- Page 19 tells you what to do if you disagree with a Medicare decision or the amount of payment on a claim.
- Page 23 tells you what to do if you have other insurance that pays before Medicare.

If you have questions about whether you can get Medicare or about Medicare enrollment, cards, or premium amounts, contact Social Security. If you have questions about the status of your Medicare Part B claims and what Medicare medical insurance covers, call your Medicare carrier. Carrier telephone numbers are listed on pages 30 to 34 of this handbook.

People who can get Medicare because of kidney disease may contact Social Security to get a copy of Medicare Coverage of Kidney Dialysis and Kidney Transplant Services. This booklet is also available at the Consumer Information Center (see inside back cover).

GENERAL INFORMATION ABOUT MEDICARE

This section tells you about:

* What is Medicare? 1
* Beneficiary Complaints 2
* Prepaid Health Care Organizations 3
* Your Medicare Card 4
* Buying Health Insurance to Supplement Medicare 4
* Fraud and Abuse Hot Line 5
* Financial Assistance for Low-Income Beneficiaries 5

WHAT IS MEDICARE?

The Medicare program is a Federal health insurance program for people 65 or older and certain disabled people. It is run by the Health Care Financing Administration of the U.S. Department of Health and Human Services. Social Security Administration offices across the country take applications for Medicare and provide general information about the program.

The Two Parts of Medicare

There are two parts to the Medicare program. Hospital Insurance (Part A) helps pay for inpatient hospital care, some inpatient care in a skilled nursing facility, home health care and hospice care. Medical Insurance (Part B) helps pay for doctors' services, outpatient hospital services, durable medical equipment, and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare.

Part B of Medicare has premiums, deductibles, and coinsurance amounts that you must pay yourself or through coverage by another insurance plan. Part A has deductibles and coinsurance, but most people do not have to pay premiums for Part A (see page 21). The amounts you pay are set each year, according to formulas established by law. New payment amounts begin each January 1. When amounts increase, you will be notified. For 1990 deductible, premium and coinsurance amounts, see the Medicare Ready Reference at the front of this handbook.

Who Can Get Medicare Benefits?

Generally, people age 65 and over can get premium-free Medicare hospital insurance (Part A) benefits, based on their own or their spouses' employment. You can get Medicare Part A if you are 65 or over and:

- receive benefits under the Social Security or Railroad Retirement system,
- could receive benefits under Social Security or Railroad Retirement system but did not file for them, or
- you or your spouse had certain government employment.

If you are under 65 you can get premium-free Medicare hospital insurance (Part A) benefits if you:

- have been a Social Security or Railroad Retirement Board disability beneficiary for more than 24 months.

Certain government employees and certain members of their families can also get Medicare when they are disabled for more than 29 months. They should apply with the Social Security Administration as soon as they become disabled.

Or, you may be able to get premium-free Medicare hospital insurance (Part A) benefits if you receive continuing dialysis for permanent kidney failure or had a kidney transplant.

No one needs to have worked more than 10 years to be able to get premium-free Medicare hospital insurance benefits. Check with Social Security to see if you have worked long enough under Social Security, Railroad Retirement, as a government employee, or a combination of these systems to be able to get Medicare hospital insurance benefits.

Who Can Get Medicare medical insurance (Part B)?

Any person who can get premium-free Medicare hospital insurance benefits based on work as described above can enroll for Part B, pay the monthly Part B premiums, and get Part B benefits.

Buying Medicare hospital insurance and medical insurance

If you do not have enough work credits to be able to get Medicare hospital insurance benefits and you are 65 or over, you may be able to buy Medicare hospital and medical insurance—or just Medicare medical insurance—by paying monthly premiums.* Check with Social Security or Railroad Retirement to find out about buying into Medicare.

*Also, on and after July 1, 1990, you may be able to buy Medicare hospital insurance and medical insurance if you are disabled and lost your premium-free hospital insurance solely because you are working.

Enrollment in Medicare

If you are getting Social Security or Railroad Retirement benefit payments when you turn 65, you will get a Medicare card in the mail. The card will show that you can get both Medicare hospital insurance (Part A) and medical insurance (Part B) benefits. If you do not want Part B, follow the instructions that come with the card.

The above process also applies when you have been a Social Security or Railroad Retirement disability beneficiary for 24 months. A Medicare card will come in the mail.

Some people must file an application to get Medicare benefits. If you have not applied for Social Security or Railroad Retirement benefits, if government employment is involved, or if you have kidney disease, you must file an application for Medicare. Check with Social Security if you are able to get Medicare under the Social Security system or based on certain government employment; or with Railroad Retirement if you are able to get Medicare under the Railroad Retirement system.

If you must file an application for Medicare, you should do so during your initial enrollment period, to avoid late enrollment penalties under Medicare medical insurance. Your initial enrollment period is the seven-month period beginning three months prior to the month you are first able to get Medicare. If you do not enroll for Medicare during the first three months of your initial enrollment period, there will be a delay in starting your medical insurance coverage. Your coverage will be delayed from one to three months after enrollment.

If you do not enroll for Medicare medical insurance at any time during your initial enrollment period there will be a delay of from four to 16 months in starting your coverage and you may be charged a premium penalty for late enrollment (unless you qualify for a special enrollment period as described on page 21).

Intermediaries and Carriers

The Federal government contracts with private insurance organizations called intermediaries and carriers to process claims and make Medicare payments. Intermediaries handle claims submitted on your behalf by hospitals, skilled nursing facilities, home health agencies, hospices and other providers of services. Carriers handle claims for services by doctors and other suppliers covered under Medicare's medical insurance program.

Peer Review Organizations

Peer Review Organizations (PROs) are groups of practicing doctors and other health care professionals who are paid by the Federal government to review the care given to Medicare patients. Each State has a PRO that decides, for Medicare payment purposes, whether care is reasonable and necessary, is provided in the appropriate setting, and meets the standards of quality accepted by the medical profession. PROs have the authority to deny payments if care is not medically necessary or not delivered in the most appropriate setting.

Medicare law requires doctors who do not take assignment for elective surgery to give you a written estimate of your costs before the surgery if the total charge is $500 or more. If the doctor does not give you a written estimate, you are entitled to a refund of any amount you paid him or her over the Medicare approved amount.

PROs respond to requests for review of notices of noncoverage issued by hospitals to beneficiaries; and PROs respond to beneficiary, physician, and hospital requests for reconsideration of PRO decisions. PROs also investigate individual patient complaints about the quality of care. (For more information about how PROs handle beneficiary complaints, see below).

If you are admitted to a Medicare participating hospital, you will receive An Important Message From Medicare which explains your right as a hospital patient and provides the name, address, and phone number of the PRO for your State. A copy of the message is printed on page 28.

If you feel that you are improperly refused admission to a hospital or that you are forced to leave the hospital too soon, ask for a written explanation of the decision. Such a written notice must fully explain how you can appeal the decision and it must give you the name, address, and phone number of the PRO where your appeal or request for review can be submitted. (See page 19 for a more complete discussion of your appeal rights under Medicare.)

BENEFICIARY COMPLAINTS

PROs are responsible for reviewing beneficiary complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments and hospital emergency rooms; skilled nursing facilities; home health agencies; ambulatory surgical centers; and certain health maintenance organizations.

If you believe that you have received poor quality care provided by one of these types of facilities, you may complain to the PRO. The PRO will investigate written complaints from beneficiaries, or their representatives, about the quality of Medicare services received.

The complaint must be written and the PRO will help you put your complaint in writing if you wish. If someone else makes a complaint for you or on your behalf, you must give written permission for that person to represent you in the complaint.

You will find a list of Medicare PROs on page 35.

PREPAID HEALTH CARE ORGANIZATIONS

Some prepaid health care organizations such as health maintenance organizations (HMOs) and competitive medical plans (CMPs) contract with Medicare to provide services to Medicare beneficiaries. These prepaid health care organizations receive direct payments from Medicare for their services.

You may enroll in a prepaid health care organization's plan rather than receive your benefits under Medicare's traditional fee-for-service system. Most HMOs and CMPs provide all Medicare hospital and medical insurance benefits to their Medicare enrollees.

HMOs and CMPs generally cover most of your health care costs, charging you fixed monthly premiums and minimal coinsurance payments. HMOs and CMPs also reduce the amount of paperwork you have because you generally do not have to file any claims. Many organizations offer additional services beyond what Medicare covers at little or no additional cost: such things as preventive care, dental care, hearing aids and eyeglasses. During 1990 most HMOs and CMPs that enroll Medicare beneficiaries are required by law to provide certain benefits not available under fee-for-service Medicare at no additional charge to you. These include extended hospital and skilled nursing facility stays, expanded home health benefits, respite care, and coverage for certain drugs.

If you are thinking about choosing a prepaid health care organization plan under contract to Medicare, here are some requirements and restrictions to consider:

- You must be enrolled in Medicare's medical insurance (Part B) and continue to pay the premiums.
- You must live within the area serviced by the HMO or CMP.
- You will usually be required to receive all care from the HMO or CMP, except in emergency or urgent situations.
- If you have elected hospice care, you cannot enroll in an HMO or CMP as long as the hospice election remains in effect. But,

  —after you become a member of an HMO or CMP, you may elect hospice benefits and continue in the organization's plan. In this case, you must receive all care related to your terminal illness from the hospice instead of the HMO or CMP.
- You cannot enroll in an HMO or CMP if you have chronic kidney disease. But,

  —if you are a member of an HMO or CMP when you develop chronic kidney disease, the care you need will be provided through the organization.

You can enroll in a Medicare HMO or CMP and later decide you prefer the traditional fee-for-service Medicare. If this happens, you can drop the HMO or CMP plan in any month and transfer to fee-for-service Medicare at the beginning of the following month. Your HMO or CMP or Social Security can help you transfer.

If you already belong to a Medicare HMO or CMP and you are unhappy with the quality of care, you can:

- follow your HMO or CMP's grievance procedure, or
- complain to your Peer Review Organization (PRO) or Quality Review Organization (QRO). PROs and QROs are groups of practicing doctors and other health care professionals under contract to Medicare to review the care provided to Medicare patients. (See page 2).

You can contact your HMO or CMP to get the name, address and phone number of your PRO or QRO. PROs and QROs are also listed on page 35.

If you believe that your HMO or CMP has made an incorrect decision on coverage of benefits or payment of a claim, you can exercise your appeal rights—rights that are similar to those that are guaranteed under traditional fee-for-service Medicare (see page 20).

If you want to get information about how to enroll in an HMO or CMP, what benefits are provided, and what the membership rules are, you should contact the HMO or CMP plan directly. HMOs and CMPs generally advertise when enrollment is open to Medicare beneficiaries.

YOUR MEDICARE CARD

The Medicare card shows the Medicare coverage you have (hospital insurance (Part A), medical insurance (Part B), or both) and the date your protection started. If you don't have both parts of Medicare, see page 21 for information on how you may obtain the part you don't have.

Your card also shows your health insurance claim number. Sometimes this claim number is referred to as your Medicare number. The claim number has nine digits and a letter. On some cards, there may also be another number after the letter. Your full claim number must always be included on all Medicare claims and correspondence. When a husband and wife both have Medicare, each receives a separate card and claim number. Each spouse must use the exact name and claim number shown on his or her card.

It is important that you remember to:

(1) Always show your Medicare card when you receive services that Medicare helps pay for.

(2) Always write your health insurance claim number (including the letter) on any bills you send in and on any correspondence about Medicare. Also, you should have your Medicare card available when you make a telephone inquiry.

(3) Carry your card with you whenever you are away from home.

(4) Immediately ask Social Security to get you a new card if you lose yours.

(5) Use your Medicare card only after the effective date shown on it.

(6) Never let someone else use your Medicare card.

BUYING HEALTH INSURANCE TO SUPPLEMENT MEDICARE

Medicare provides basic protection against the high cost of health care, but it will not pay all of your medical expenses, nor most long term care expenses. For this reason, many private insurance companies sell insurance to supplement Medicare (Medigap insurance). The Federal Government does not sell or service such insurance.

If you are thinking about buying a new private insurance policy or replacing an old policy to supplement your Medicare protection, you should shop carefully. You can get a pamphlet, Guide to Health Insurance for People with Medicare to help you make Medicare supplement decisions. The guide explains how supplemental insurance works and how to shop for it. The guide also lists the names, addresses and telephone numbers of your State Insurance Department and your State Agency on Aging. These offices can provide you valuable help in making your decision about whether to buy insurance to supplement Medicare. You may order a copy of the guide from the Consumer Information Center (see inside back cover).

Some beneficiaries cancelled their Medicare supplement policies in 1989, anticipating new Medicare benefits under the Medicare Catastrophic Coverage Act. Since this law was repealed and catastrophic health coverage ended on December 31, 1989, some beneficiaries may wish to repurchase their Medicare supplement insurance. The law repealing the Medicare Catastrophic Coverage Act allowed for repurchase.

In general, if you had a Medicare supplement policy in effect on December 31, 1988, and cancelled that policy in 1989 without replacing it with another policy, you should have been offered the opportunity to renew the policy. Your insurance company should have offered you the opportunity to renew your old policy no later than January 30, 1990. You would have had 60 days to renew your old policy from the date your insurance company's offer was made. Coverage would have been effective back to January 1, 1990.

There are Federal criminal and civil penalties (fines) for certain actions in selling health insurance to supplement Medicare. These penalties may be imposed against any insurance company or agent who knowingly sells you a policy that promises to duplicate Medicare coverage or any private health insurance that you already own but which, in reality, will not pay duplicate benefits. Penalties also apply if insurance agents misrepresent to you that they are employees or agents of the Medicare program or of any Government agency. There is also a penalty for making a false statement about a policy's meeting legal standards for certification when it does not, and for using the mails in a State for delivering advertisements of health insurance policies to supplement Medicare if the policies have not been approved for sale in that State.

If you suspect that you have been the victim of these or any other illegal sales practices, you should contact your State Insurance Department. The telephone numbers to call are listed in the back of the pamphlet, Guide to Health Insurance for People with Medicare. (See above for how to

order the guide.) Or, you may call this toll-free number: 1-800-638-6833 (In Maryland,1-800-492-6603).

FRAUD AND ABUSE HOT LINE

If you have reason to believe that a doctor, hospital, or other provider of health care services is performing unnecessary or inappropriate services or is billing Medicare for services you did not receive, you may call a toll-free Hot Line. The Hot Line has been installed by the Department of Health and Human Services' Inspector General to receive any evidence of such fraud or abuse of the Medicare program.

The toll-free number is 1-800-368-5779. In Maryland, call 1-800-638-3986. Please do not call the Inspector General's Hot Line for Medicare policy questions or questions about delayed claims or payments.

FINANCIAL ASSISTANCE FOR LOW- INCOME BENEFICIARIES

If you meet certain income and resource tests, your State may consider you a qualified Medicare beneficiary. If you are a qualified Medicare beneficiary, your State's medical assistance (Medicaid) program will pay your share of health care costs under Medicare. To qualify:

- your annual income level must be at or below the national poverty level* and
- you can not have access to many financial resources such as bank accounts or stocks and bonds.

State governments assist qualified Medicare beneficiaries by paying the monthly Medicare premiums. And qualified Medicare beneficiaries do not have to pay Medicare deductibles and copayments.

Each State sets its own guidelines for who qualifies for this assistance. The maximum annual income level for qualification varies by State. If you think you may qualify, you should contact your State or local welfare, social service or public health agency.

*Poverty levels were set in 1989 at $5980 for one person or $8020 for a family of two. Levels for 1990, not available at press time, will be slightly higher.

HOSPITAL INSURANCE

This section tells you about:

* The Prospective Payment System 5
* Medicare Hospital Insurance 5
* When You Are A Hospital Inpatient 6
* Skilled Nursing Facility Care 8
* Home Health Care 9
* Hospice Care 10

THE PROSPECTIVE PAYMENT SYSTEM

Medicare pays for most inpatient hospital care under the Prospective Payment System (PPS). Under PPS, hospitals are paid fixed amounts based on the principal diagnosis for each Medicare hospital stay. The payment categories are called Diagnosis Related Groups, or DRGs. In some cases, the Medicare payment will be more than the hospital's costs; in other cases, the payment will be less than the hospital's costs. In special cases, where costs for necessary care are unusually high or the length of stay is unusually long, the hospital receives additional payment. But even if Medicare pays the hospital less than the cost of your care, you do not have to make up the difference.

It is important to remember that the PPS system does not change your Medicare hospital insurance protection as described in this handbook. PPS does not determine the length of your stay in the hospital or the extent of care you receive. The law requires participating hospitals to accept Medicare payments as payment in full, and those hospitals are prohibited from billing the Medicare patient for anything other than the applicable deductible and coinsurance amounts, plus any amounts due for noncovered items or services, such as television, telephone or private duty nurses.

MEDICARE HOSPITAL INSURANCE

Medicare hospital insurance helps pay for four kinds of medically necessary care: (1) inpatient hospital care; (2) inpatient care in a skilled nursing facility following a hospital stay; (3) home health care; and (4) hospice care.

There is a limit on how many days of hospital or skilled nursing facility care Medicare helps pay for in each benefit period. But, your hospital insurance protection is renewed every time you start a new benefit period.

Skilled nursing facility care is the only type of nursing home care that Medicare covers. Medicare does not pay for care that is primarily custodial. (See page 20 for an explanation).

Benefit Periods

A benefit period is a way of measuring your use of services under Medicare hospital insurance. Your first benefit period starts the first time you enter a hospital after your hospital insurance begins. A benefit period ends when you have been out of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row (including the day of discharge). There is no limit to the number of benefit periods you can have for hospital and skilled nursing facility care. However, special limited benefit periods apply to hospice care (see page 10).

Here are two examples of how the benefit period works:

Example 1: Mrs. Jones enters the hospital on January 5th. She is discharged on January 15th. She has used 10 days of her first benefit period. Mrs. Jones is not hospitalized again until July 20th. Since more than 60 days elapsed between her hospital stays, she begins a new benefit period, and her hospital insurance coverage is completely renewed.

Example 2: Mrs. Smith enters the hospital on August 14th. She is discharged on August 24th. She also has used 10 days of her first benefit period. However, she is then readmitted to the hospital on September 20th. Since fewer than 60 days elapsed between hospital stays, Mrs. Smith is still in her first benefit period and the first day of her second admission is counted as the 11th day of hospital care in that benefit period. Mrs. Smith will not begin a new benefit period until she has been out of the hospital (or skilled nursing facility) for 60 consecutive days.

Medicare hospital insurance helps pay for most but not all of the services you receive in a hospital or skilled nursing facility or from a home health agency or hospice program. There are covered services and noncovered services under each kind of care. Covered services are services and supplies that hospital insurance pays for.

Hospitals, skilled nursing facilities, home health agencies and hospices are participating providers under the Medicare hospital insurance program. They submit their claims directly to Medicare—you cannot submit claims for their services. The provider will charge you for any part of the hospital insurance deductible you have not met and any coinsurance payment you owe.

When a hospital, skilled nursing facility, home health agency, or hospice sends Medicare a hospital insurance claim for payment, you get a Medicare Benefit Notice that explains the decision made on the claim. If you have any questions about the notice, get in touch with the office shown on the notice.

WHEN YOU ARE A HOSPITAL INPATIENT

Medicare hospital insurance helps pay for inpatient hospital care if all of the following four conditions are met: (1) a doctor prescribes inpatient hospital care for treatment of your illness or injury, (2) you require the kind of care that can only be provided in a hospital, (3) the hospital is participating in Medicare,* and (4) the Utilization Review Committee of the hospital or a Peer Review Organization does not disapprove your stay.

If you meet these four conditions, Medicare will pay** for up to 90 days of medically necessary inpatient hospital care in each benefit period.

During 1990, from the 1st day through the 60th day in a hospital during each benefit period, hospital insurance pays for all covered services except the first $592. This is called the hospital insurance deductible. (A deductible is an amount you owe before Medicare begins paying for services and supplies covered by the program.) The hospital may charge you the deductible only for your first admission in each benefit period. If you are discharged and then readmitted before the benefit period ends, you do not have to pay the deductible again. And if you paid a hospital deductible in December of 1989, you do not have to pay a deductible again in January if you are still a patient in or are readmitted to a hospital in January of 1990.

From the 61st through the 90th day in a hospital during each benefit period, hospital insurance pays for all covered services except for $148 a day. This daily amount is called hospital insurance coinsurance. The hospital charges you the $148.

Page 7 explains how hospital reserve days can help with your expenses if you need more than 90 days of inpatient hospital care in a benefit period.

*Under certain conditions, Medicare helps pay for emergency inpatient care you receive in a non-participating hospital.

**Medicare pays for only limited care in an inpatient psychiatric hospital (see page 8). The hospital can tell you about these limits.

Medicare hospital insurance does not help pay for your doctor's services even though you receive them in a hospital. Doctors' services are covered under Medicare medical insurance. Page 12 tells how Medicare helps with doctor bills.

Major services covered when you are a hospital inpatient

Medicare hospital insurance pays for these services:

- A semiprivate room (2 to 4 beds in a room)
- All your meals, including special diets
- Regular nursing services
- Costs of special care units, such as intensive care or coronary care unit
- Drugs furnished by the hospital during your stay
- Blood transfusions furnished by the hospital during your stay
- Lab tests included in your hospital bill
- X-rays and other radiology services, including radiation therapy, billed by the hospital
- Medical supplies such as casts, surgical dressings, and splints
- Use of appliances, such as a wheelchair
- Operating and recovery room costs, including hospital costs for anesthesia services
- Rehabilitation services, such as physical therapy occupational therapy, and speech pathology services

Some services not covered when you are a hospital inpatient

Medicare hospital insurance does not pay for these services:

- Personal convenience items that you request such as a telephone or television in your room
- Private duty nurses
- Any extra charges for a private room unless it is determined to be medically necessary

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision. (See page 19.)

Hospital Inpatient Reserve Days

We said earlier that Medicare helps pay for your care in a hospital for up to 90 days in each benefit period. But Medicare hospital insurance includes an extra 60 hospital days you can use if you have a long illness and have to stay in the hospital for more than 90 days. These extra days are called reserve days. Once you use a reserve day you never get it back. Reserve days are not renewable like your 90 hospital days in each benefit period.

During 1990, hospital insurance pays for all covered services except $296 a day for each reserve day you use. You are responsible for paying this $296.

You have only 60 reserve days in your lifetime, and you can decide when you want to use them. After you have been in the hospital 90 days, you can use all or some of your 60 reserve days if you wish. But you do not have to use your reserve days right away if you do not want to. Some private insurance plans help pay Medicare hospital bills for illnesses that keep beneficiaries in the hospital for more than 90 days.

If you do not want to use your reserve days, you must tell the hospital in writing before your 90th day. Otherwise, the extra days you need to be in the hospital will automatically be taken from your reserve days.

Coverage of Blood Under Hospital Insurance

Hospital insurance helps pay for blood (whole blood or units of packed red blood cells), blood components, and the cost of blood processing and administration. If you receive blood as an inpatient of a hospital or skilled nursing facility, hospital insurance will pay for these blood costs, except for any nonreplacement fees charged for the first 3 pints of whole blood or units of packed red cells per calendar year. The nonreplacement fee is the charge that some hospitals and skilled nursing facilities make for blood which is not replaced.

You are responsible for the nonreplacement fees for the first 3 pints or units of blood furnished by a hospital or skilled nursing facility. If you are charged nonreplacement fees, you have the option of either paying the fees or having the blood replaced. If you choose to have the blood replaced, you can either replace the blood personally or arrange to have another person or a blood assurance plan replace it for you. A hospital or skilled nursing facility cannot charge you for any of the first 3 pints of blood you replace or arrange to replace. (If you have already paid for or replaced blood under Medicare medical insurance during the

calendar year, you do not have to meet those costs again under Medicare hospital insurance. See page 16 an for explanation of coverage of blood under Medicare medical insurance.)

Care In A Psychiatric Hospital

Hospital insurance helps pay for no more than 190 days of inpatient care in a participating psychiatric hospital in your lifetime. Once you have used these 190 days, hospital insurance does not pay for any more inpatient care in a psychiatric hospital.

Also, there is a special rule that applies if you are in a participating psychiatric hospital at the time your hospital insurance starts. Social Security can give you information about this special rule.

Care in a Foreign Hospital

Medicare generally does not pay for hospital or medical services outside the United States. (Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the United States, along with the 50 States and the District of Columbia.) However, it helps pay for care in qualified Canadian or Mexican hospitals in three situations. These are: (1) you are in the U.S. when an emergency occurs and a Canadian or Mexican hospital is closer than the nearest U.S. hospital that can provide the emergency services you need,* (2) you live in the U.S. and a Canadian or Mexican hospital is closer to your home than the nearest U.S. hospital that can provide the care you need, regardless of whether or not an emergency exists, and (3) you are in Canada traveling by the most direct route to or from Alaska and another State and an emergency occurs that requires that you be admitted to a Canadian hospital.

When hospital insurance covers your inpatient stay in a Canadian or Mexican hospital, your medical insurance can cover necessary doctors' services and any required use of an ambulance. If the hospital does not submit the claim to Medicare, Social Security can help you get Medicare payment for the covered services you receive. If you are planning to travel outside the United States, you may want to inquire about the availability of special short-term health insurance for foreign travel.

*Medicare may not pay if you leave the United States for purposes other than to obtain medical treatment (for example, where the foreign hospital is more accessible simply because your departure was part of a vacation or business trip and you were already involved in the process of travel), even though the medical emergency occurred within United States territory.

Care in a Christian Science Sanatorium

Medicare hospital insurance helps pay for inpatient hospital and skilled nursing facility services you receive in a participating Christian Science sanatorium if it is operated or listed and certified by the First Church of Christ, Scientist, in Boston.

SKILLED NURSING FACILITY CARE

Medicare hospital insurance helps pay for inpatient care in a Medicare-participating skilled nursing facility following a hospital stay if your condition requires daily skilled nursing or rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility.

A skilled nursing facility is a specially qualified facility which has the staff and equipment to provide skilled nursing care or rehabilitation services and other related health services. Most nursing homes in the United States are not skilled nursing facilities, and many skilled nursing facilities are not participating in Medicare. In some facilities, only certain portions participate in Medicare. If you are not sure whether a facility or a particular portion of a facility participates in Medicare as a skilled nursing facility, ask someone at the facility. If staff at the facility cannot tell you, ask Social Security to check with the Health Care Financing Administration.

Hospital insurance helps pay for care in a skilled nursing facility if all of the following five conditions are met:

(1) you have been in a hospital at least three days in a row (not counting the day of discharge) before your transfer to a participating skilled nursing facility,

(2) you are transferred to the skilled nursing facility because you require care for a condition which was treated in the hospital,

(3) you are admitted to the facility within a short time (generally within 30 days) after you leave the hospital,

(4) a doctor certifies that you need, and you receive, skilled nursing or skilled rehabilitation services on a daily basis, and

(5) the Medicare intermediary or the facility's Utilization Review Committee does not disapprove your stay.

All conditions must be met. But it is especially important to remember the requirement that you must need skilled nursing care or skilled rehabilitation services on a daily basis.

Skilled nursing care means care that can only be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services may include such services as physical therapy performed by, or under the supervision of, a professional therapist. The skilled nursing care and skilled rehabilitation services you receive must be based on a doctor's orders.

Hospital insurance will not pay for your stay if you need skilled nursing or rehabilitation services only occasionally, such as once or twice a week, or if you do not need to be in a skilled nursing facility to get skilled services. Also, hospital insurance will not pay for your stay if you are in a skilled nursing facility mainly because you need custodial care (see page 20).

When your stay in a skilled nursing facility is covered by Medicare, hospital insurance helps pay for up to 100 days each benefit period, but only if you need daily skilled nursing care or rehabilitation services for that long.

If you leave a skilled nursing facility and are readmitted within 30 days, you do not have to have a new 3-day stay in the hospital for your care to be covered. If you have some of your 100 days left and you need skilled nursing or rehabilitation services on a daily basis for further treatment of a condition treated during your previous stay in the facility, Medicare will help pay.

In each benefit period, hospital insurance pays for all covered services for the first 20 days you are in a skilled nursing facility. During 1990, for the 21st through the 100th day, hospital insurance pays for all covered services except for $74.00 a day. You may be charged up to this amount by the skilled nursing facility.

Hospital insurance does not cover your doctor's services while you are in a skilled nursing facility. Medicare medical insurance covers doctors' services. Page 12 tells you how Medicare helps with doctor bills.

Major services covered when you are in a skilled nursing facility

Medicare hospital insurance pays for these services:

- A semiprivate room (2 to 4 beds in a room)
- All your meals, including special diets
- Regular nursing services
- Rehabilitation services, such as physical, occupational, and speech therapy
- Drugs furnished by the facility during your stay
- Blood transfusions furnished to you during your stay (see page 7 for information about coverage of blood)
- Medical supplies such as splints and casts
- Use of appliances such as a wheelchair

Some services not covered when you are in a skilled nursing facility

Medicare hospital insurance does not pay for these services:

- Personal convenience items that you request such as a television in your room
- Private duty nurses
- Any extra charges for a private room, unless it is determined to be medically necessary
- Custodial nursing home care services

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision. (See page 19.)

HOME HEALTH CARE

If you need skilled health care in your home for the treatment of an illness or injury, Medicare pays for covered home health services furnished by a participating home health agency. A home health agency is a public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy in your home. (A facility that mainly provides skilled nursing or rehabilitation services cannot be considered your home.)

Medicare pays for home health visits only if all of the following conditions are met:

(1) The care you need includes intermittent skilled nursing care, physical therapy, or speech therapy,
(2) You are confined to your home,
(3) You are under the care of a physician who determines you need home health care and sets up a home health plan for you, and
(4) The home health agency providing services is participating in Medicare.

Once these conditions are met, either hospital insurance or medical insurance will pay for all medically necessary home health services. When you no longer need intermittent skilled nursing care, physical therapy, or speech

therapy, Medicare will pay for home health services if you continue to need occupational therapy.

Medicare home health services do not include coverage for general household services, meal preparation, shopping, or other home care services furnished mainly to assist people in meeting personal, family, or domestic needs.

To determine whether you can get services under the Medicare home health benefit, ask your physician to refer you to a Medicare participating home health agency. The home health agency will evaluate your case to advise you about whether you meet the requirements for Medicare coverage. Home health agencies do not charge for this evaluation.

Home health services covered by Medicare

Medicare pays for these services:

- Part-time or intermittent skilled nursing care (This can include eight hours of reasonable and necessary care per day for up to 21 consecutive days—or longer in certain circumstances.)
- Physical therapy
- Speech therapy

If you need intermittent skilled nursing care, or physical or speech therapy, Medicare also pays for:

- Occupational therapy
- Part-time or intermittent services of home health aides
- Medical social services
- Medical supplies
- Durable medical equipment (80 percent of approved amount)

Home health services not covered by Medicare

Medicare does not pay for these services:

- 24-hour-a-day nursing care at home
- Drugs and biologicals
- Meals delivered to your home
- Homemaker services
- Blood transfusions

Medicare pays the full approved cost of all covered home health visits. You may be charged only for any services or costs that Medicare does not cover. However, if you need durable medical equipment, you are responsible for a 20 percent copayment for the equipment.

The home health agency will submit the claim for payment. You do not have to send in any bills yourself.

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision. (See page 19.)

HOSPICE CARE

A hospice is a public agency or private organization that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people.

Hospice care is a special type of care for people who are terminally ill. It includes both home care and inpatient care, when needed, and a variety of services not otherwise covered under Medicare. Under the Medicare hospice benefit, Medicare pays for services every day and permits a hospice to provide appropriate custodial care, including homemaker services and counseling.

Medicare hospital insurance helps pay for hospice care if all of the following three conditions are met:

(1) a doctor certifies that a patient is terminally ill,
(2) a patient chooses to receive care from a hospice instead of standard Medicare benefits for the terminal illness, and
(3) care is provided by a Medicare-participating hospice program.

Special benefit periods apply to hospice care. Hospital insurance pays for a maximum of two 90-day periods and one 30-day period.*

- Hospice benefit periods may be consecutive.
- A beneficiary may disenroll from the hospice during any benefit period, return to regular Medicare coverage, then later re-elect the hospice benefit if another benefit period is available. (But the remainder of the benefit period in effect at the time of disenrollment is lost.)

There are no deductibles under the hospice benefit. The beneficiary does not pay for Medicare-covered services for the terminal illness, except for small coinsurance amounts for outpatient drugs and inpatient respite care. The patient is responsible for 5 percent of the cost of

*Even if Medicare hospice benefit periods are exhausted, if a patient wants and still needs hospice services, the hospice must continue care. The hospice may bill the patient for this continued care.

outpatient drugs or $5 toward each prescription, whichever is less. For inpatient respite care, the patient pays 5 percent of the Medicare-allowed rate (approximately $4.13 per day in 1990). The rate varies slightly depending on the area of the country.

Respite care under the hospice program is a short-term inpatient stay in a facility for the sick Medicare beneficiary. Hospice respite care gives temporary relief to the person who regularly assists with home care. Each inpatient respite care stay is limited to no more than five days in a row.

While receiving hospice care, if a patient requires treatment for a condition not related to the terminal illness, Medicare continues to help pay for all necessary covered services under the standard Medicare benefit program.

Services covered when provided by a hospice
Medicare hospital insurance pays for these services for beneficiaries as part of hospice care:

- Nursing services
- Doctors' services
- Drugs, including outpatient drugs for pain relief and symptom management
- Physical therapy, occupational therapy and speech-language pathology
- Home health aide and homemaker services
- Medical social services
- Medical supplies and appliances
- Short-term inpatient care, including respite care
- Counseling

The Medicare hospital insurance hospice benefit does not pay for treatments other than for pain relief and symptom management of a terminal illness.

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision. (See page 19)

MEDICARE MEDICAL INSURANCE

This section tells you about:

* Deductible and Coinsurance Amounts 11
* Covered Doctors' Services 12
* Second Opinion Before Surgery 13
* Services of Special Practitioners 13
* Outpatient Hospital Services 13
* Other Covered Services and Supplies 14
* Drugs and Biologicals 16
* Assignment 16
* Participating Doctors and Suppliers 17
* Participating Providers 17
* Explanation of Medicare Benefits Notice 17
* Approved or "Reasonable" Charges 18
* Medicare Payments for Outpatient Treatment of Mental Illness 18

Medicare medical insurance helps pay for (1) doctor's services, (2) outpatient hospital care, (3) diagnostic tests, (4) durable medical equipment, (5) ambulance services, and (6) many other health services and supplies which are not covered by Medicare hospital insurance.

The following sections tell you more about these different kinds of care, the services that are and are not covered by Medicare medical insurance, and what part of your medical expenses Medicare will pay.

DEDUCTIBLE AND COINSURANCE AMOUNTS UNDER MEDICARE MEDICAL INSURANCE

The Annual Deductible

You must pay the first $75 in approved charges for covered medical expenses in 1990. This is called the Medicare medical insurance annual deductible. You need to meet this $75 deductible only once during the year, and the deductible can be met by any combination of covered expenses. You do not have to meet a separate deductible for each different kind of covered service you receive.

The Blood Deductible

You must pay any nonreplacement fees charged for the first three pints or units of blood and blood components you use each year. This is called the Medicare medical insurance blood deductible. After you have replaced or paid for the first three pints of blood and you have met the $75 annual deductible, Medicare will pay 80 percent of the approved charges for blood,

starting with the fourth pint. (If you have already paid for or replaced blood under Medicare hospital insurance during the calendar year, you do not have to pay for or replace blood again under Medicare medical insurance.)

Coinsurance

After you pay the annual deductible, you will owe a share of the Medicare-approved charges for most services and supplies. This share is called coinsurance. Usually, your coinsurance share is 20 percent.

Medicare determines the "approved" or "reasonable" charge for each service you receive. If your services were provided "on assignment" (see page 16 for an explanation of assignment) you pay only the coinsurance. But if your services were not provided "on assignment" the charges for your services may be more than the Medicare-approved amount. In those cases, you owe the Medicare coinsurance plus charges above the Medicare-approved amount, in most cases.

NOTE: This explanation of your deductible and coinsurance amounts describes Medicare's payment system for most services covered by Medicare medical insurance. In cases where payment for services is handled in a different way, you will be given an explanation along with the description of services covered.

COVERED DOCTORS' SERVICES

Medicare medical insurance helps pay for covered services you receive from your doctor in his or her office, in a hospital, in a skilled nursing facility, in your home, or any other location in the U.S. Medicare sometimes helps pay for doctors' services you receive in a Canadian or Mexican hospital. See page 8 to find out about care in Canadian and Mexican hospitals.

Major doctors' services covered by Medicare

Medicare medical insurance helps pay for these services:

- Medical and surgical services, including anesthesia
- Diagnostic tests and procedures that are part of your treatment
- Radiology and pathology services by doctors while you are a hospital inpatient or outpatient
- Treatment of mental illness (Medicare payments for outpatient treatment are limited. See page 18)
- Other services which are ordinarily furnished in the doctor's office and included in his or her bill, such as:
  - — X-rays
  - — Services of your doctor's office nurse
  - — Drugs and biologicals that cannot be self-administered
  - — Transfusions of blood and blood components
  - — Medical supplies
  - — Physical/occupational therapy and speech pathology services

Some doctors' services not covered by Medicare

Medicare medical insurance does not pay for these services:

- Routine physical examinations and tests directly related to such examinations (except some pap smears on or after July 1, 1990)
- Most routine foot care
- Examinations for prescribing or fitting eyeglasses or hearing aids
- Immunizations (except pneumococcal vaccinations or immunizations required because of an injury or immediate risk of infection, and hepatitis B for certain persons at risk)
- Cosmetic surgery, unless it is needed because of accidental injury or to improve the function of a malformed part of the body

Types of Doctors

Most doctors' services are furnished by a doctor of medicine (MD) or a doctor of osteopathy (DO). Other "physicians" that can furnish some covered services include chiropractors, doctors of podiatric medicine (podiatrists), doctors of dental surgery or of dental medicine (dentists), and doctors of optometry (optometrists).

Chiropractors' services

Medicare helps pay for only one kind of treatment furnished by a licensed chiropractor: manual manipulation of the spine to correct a subluxation that can be demonstrated by X-ray. Medicare medical insurance does not pay for any other diagnostic or therapeutic services, including X-rays, furnished by a chiropractor.

Podiatrists' services

Medicare medical insurance helps pay for any covered services of a licensed podiatrist to

treat injuries and diseases of the foot. Examples of common problems include ingrown toenails, hammer toe deformities, bunion deformities and heel spurs.

Medicare generally does not pay for routine foot care such as cutting or removal of corns and calluses, trimming of nails, and other hygienic care. But, Medicare does help pay for routine foot care if you have a medical condition affecting your legs or feet (such as diabetes or vascular heart disease) which requires that such care be performed by a podiatrist or by a doctor of medicine or osteopathy.

Dentists' services

Medicare medical insurance generally does not pay for care in connection with the treatment, filling, removal, or replacement of teeth; root canal therapy; surgery for impacted teeth; and other surgical procedures involving the teeth or structures directly supporting the teeth. However, Medicare helps pay for services of a dentist in certain cases when the medical problem is more extensive than the teeth or structures directly supporting them. (If you need to be hospitalized because of the severity of a dental procedure, Medicare hospital insurance will pay for your hospital stay even if the dental care itself is not covered by Medicare.)

Optometrists' services

Medicare helps pay for optometrists services if the services are among those already covered by Medicare and if the optometrist is legally authorized to perform such services in your State. However, Medicare will not pay for routine eye exams, and it will not pay for eyeglasses or corrective lenses unless they are prosthetic lenses that replace the natural lens of the eye.

SECOND OPINION BEFORE SURGERY

Sometime your doctor may recommend surgery for the treatment of a medical problem. In some cases, surgery is unavoidable. But there is increasing evidence that many conditions can be treated equally well without surgery. Because even minor surgery involves some risk, we recommend that you get a second doctor's opinion to help you decide about surgery. Medicare will help pay for a second opinion in the same way it pays for other services by doctors. You do not have to pay a deductible or coinsurance on the second opinion.

Your own doctor is the best source for referral to another doctor. But, if you wish, you can call Medicare's Second Opinion Referral Center for the names and phone numbers of doctors in your area who provide second opinions. The toll-free number is 1-800-638-6833 (in Maryland 1-800-492-6603).

SERVICES OF SPECIAL PRACTITIONERS

Medicare medical insurance helps pay for covered services you receive from certain specially qualified practitioners who are not physicians. The practitioners must be approved by Medicare. Medicare-approved practitioners and services they can provide are listed below. These practitioners submit claims to Medicare for you:

- Certified registered nurse anesthetist —can furnish covered anesthesia services
- Certified nurse midwife—can furnish covered obstetrical and gynecological services during pregnancy
- Physician assistant—can furnish covered services to assist a doctor in a hospital or certain other facilities; or as an assistant-at-surgery; or in any location that is designated as a rural health manpower shortage area
- Clinical psychologist—can furnish covered services through a community mental health center or a rural health clinic

OUTPATIENT HOSPITAL SERVICES

Medicare medical insurance helps pay for covered services you receive as an outpatient from a participating hospital for diagnosis or treatment of an illness or injury. Under certain conditions, Medicare helps pay for emergency outpatient care you receive from a non-participating hospital.

When you go to a hospital for outpatient services, you are often asked how much of your Part B deductible you have met. One easy way to answer that question is to show the people there your most recent Explanation of Medicare Benefits notice. From this form, they usually can tell how much of the $75 annual deductible you have met.

If the hospital cannot tell how much of the $75 deductible you have met and the charge for the services you received is less than $75, the hospital may ask you to pay the entire bill. The amount you pay the hospital can be credited toward any part of the deductible you have not met. If you pay the hospital for deductible amounts you do not owe, the hospital or the Medicare intermediary will refund the amount you overpaid.

Major outpatient hospital services covered by medical insurance

Medicare medical insurance helps pay for these services:

- Services in an emergency room or outpatient clinic, including ambulatory surgical procedures
- Laboratory tests billed by the hospital
- Mental health care in a partial hospitalization psychiatric program, if a physician certifies that inpatient treatment would be required without it
- X-rays and other radiology services billed by the hospital
- Medical supplies such as splints and casts
- Drugs and biologicals that cannot be self-administered
- Blood transfusions furnished to you as an outpatient

Some outpatient hospital services not covered by medical insurance

Medicare medical insurance does not pay for these services:

- Routine physical examinations and tests directly related to such examinations (except some pap smears on or after July 1, 1990)
- Eye or ear examinations to prescribe or fit eyeglasses or hearing aids
- Immunizations (except pneumococcal and Hepatitis B vaccinations, or immunizations required because of an injury or immediate risk of infection)
- Most routine foot care

OTHER COVERED SERVICES AND SUPPLIES

Ambulatory surgical services

An ambulatory surgical center is a facility that provides surgical services that do not require a hospital stay. Medicare medical insurance (Part B) will pay for the use of an ambulatory surgical center for certain approved surgical procedures. However, by law Medicare can only pay centers that have an agreement with Medicare to participate in the Medicare program. The center can be affiliated with a hospital or it can be independently operated. In addition to helping pay for the use of the ambulatory surgical center, Medicare also helps pay for physicians' and anesthesia services that are provided in connection with the procedure.

Home Health Services

If you have both Medicare hospital insurance (Part A) and medical insurance (Part B), your hospital insurance pays for home health services. But Part B will pay for home health services if you do not have Part A. Medicare home health services are described on page 9.

Outpatient physical and occupational therapy and speech pathology services

Medicare medical insurance helps pay for medically necessary outpatient physical and occupational therapy or speech pathology services, if all the following three conditions are met:

(1) your doctor prescribes the service,
(2) your doctor or therapist sets up the plan of treatment, and
(3) your doctor periodically reviews that plan.

You may receive physical therapy, occupational therapy or speech pathology services as an outpatient of a participating hospital or skilled nursing facility, or from a participating home health agency, rehabilitation agency, or public health agency. The provider of services always submits the claim to Medicare and may only charge you for any part of the $75 annual deductible you have not met, 20 percent of the remaining approved amount, and any noncovered services.

Also, you may receive services directly from an independently practicing, Medicare-approved physical or occupational therapist in his or her office or in your home if such treatment is prescribed by a doctor. But, the maximum amount Medicare pays for each of these services provided by an independently practicing physical or occupational therapist in 1990 is $600 a year.* The Medicare payment would be less than $600 if charges for these services are used to meet part or all of your $75 annual deductible. Either you or the therapist can submit the claim to Medicare as described on page 23.

Comprehensive outpatient rehabilitation facility services

Under certain circumstances, Medicare helps pay for outpatient services you receive from a Medicare-participating comprehensive outpatient rehabilitation facility (CORF). Covered services include physicians' services; physical, speech, occupational and respiratory therapies; counseling; and other related services. You must be referred by a physician who certifies that you need skilled rehabilitation services. The CORF

* This is 80 percent of the maximum approved amount of up to $750.

submits the claim to Medicare for you. For most CORF services, you are responsible only for the annual deductible and 20 percent of the Medicare approved charges. Medicare helps pay for mental health treatment in a CORF; the Medicare payment limit for mental health treatment in a CORF is discussed on page 18.

Rural Health Clinic Services

Medicare medical insurance helps pay for services of physicians, nurse practitioners, physician assistants, nurse midwives, visiting nurses (under certain conditions), clinical psychologists, and clinical social workers furnished by a rural health clinic. The clinic submits the claim to Medicare for you. You are responsible only for the Part B annual deductible plus 20 percent of the Medicare approved charge for the clinic.

Independent clinical laboratory services

Medicare medical insurance pays the full approved fee for covered clinical diagnostic tests provided by independent laboratories that are approved to perform them. The laboratory must accept assignment for these tests. It may not bill you for the tests.

Not all laboratories are approved by Medicare and some laboratories are approved only for certain kinds of tests. If a doctor prescribes tests which the laboratory is not approved to perform, Medicare does not pay for the tests, and you can be required to pay for them. Your doctor can usually tell you which laboratories are approved and whether the tests he or she is prescribing from an approved laboratory are covered by Medicare. Your doctor must accept assignment for covered clinical diagnostic laboratory tests which he or she furnishes. He or she may not bill you for them.

Portable diagnostic x-ray services

Medicare medical insurance helps pay for portable diagnostic X-ray services you receive in your home if they are ordered by a doctor and if provided by a Medicare-approved supplier.

Other Diagnostic Tests

Medicare medical insurance also helps pay for other diagnostic tests, including X-rays, that your doctor orders to evaluate your medical problems.

Radiation Therapy

Medicare medical insurance helps pay for radiation therapy furnished under the supervision of your doctor.

Kidney Dialysis and Transplants

For detailed information on kidney transplants and renal dialysis, you can get a copy of Medicare Coverage of Kidney Dialysis and Kidney Transplant Services, available from Social Security or the Consumer Information Center (see inside back cover).

Ambulance transportation

Medicare medical insurance helps pay for medically necessary ambulance transportation but only if (1) the ambulance, equipment and personnel meet Medicare requirements, and (2) transportation in any other vehicle could endanger your health.

Under these conditions, Medicare helps pay for ambulance transportation but only to a hospital or skilled nursing facility, or from a hospital or skilled nursing facility to your home. Also, if you are an inpatient in a hospital or Medicare-participating skilled nursing facility which cannot provide a medically necessary service, Medicare helps pay for round trip ambulance transportation to the nearest appropriate facility.

Medicare does not pay for ambulance use from your home to a doctor's office.

Medicare usually helps pay only if the ambulance transportation is in your local area. But, if there are no local facilities equipped to provide the care you need, Medicare helps pay for necessary ambulance transportation to the closest facility outside your local area that can provide the necessary care. If you choose to go to another institution that is farther away, Medicare payment is based on the reasonable charge for transportation to the closest facility that can provide the necessary care.

Necessary ambulance services in connection with a covered inpatient stay in a Canadian or Mexican hospital (see page 8) are also covered by Medicare.

Durable Medical Equipment

Medicare medical insurance helps pay for durable medical equipment such as oxygen equipment, wheelchairs, and other medically necessary equipment that your doctor prescribes for use in your home. (A hospital or facility that mainly provides skilled nursing or rehabilitation services cannot be considered your home.)

To be considered durable medical equipment, the equipment must be able to be used over again by other patients, must primarily serve a medical purpose, must not be useful to people who are not sick or injured, and

must be appropriate for use in your home. Not all types of equipment that you might find useful can meet all four of these requirements.

NOTE: The durable medical equipment supplier must have your doctor's prescription before delivering any of the following items: seat lift chairs, power-operated vehicles, equipment for care of pressure sores, or transcutaneous electrical nerve stimulators.

Generally, Medicare pays for durable medical equipment on a rental basis. However, Medicare pays for the purchase of some types of equipment. Your Medicare carrier will be able to provide more specific guidance on these rules. (Carriers are listed on pages 30 to 34)

Prosthetic devices

Medicare medical insurance helps pay for prosthetic devices needed to substitute for an internal body organ. These include Medicare-approved corrective lenses needed after a cataract operation, colostomy or ileostomy bags and certain related supplies, and breast prostheses (including a surgical brassiere) after a mastectomy. Medicare also helps pay for artificial limbs and eyes, and for arm, leg, back, and neck braces. Medicare does not pay for orthopedic shoes unless they are an integral part of leg braces and the cost is included in the charge for the braces. Medicare does not pay for dental plates or other dental devices.

Medical supplies

Medicare medical insurance helps pay for surgical dressings, splints, and casts ordered by a doctor in connection with your medical treatment. This does not include adhesive tape, antiseptics, or other common first-aid supplies.

DRUGS AND BIOLOGICALS

Pneumococcal vaccine

Medicare medical insurance pays the full approved charges for pneumococcal vaccine and its administration. Neither the $75 annual deductible nor the 20 percent coinsurance apply to this service.

Hepatitis B vaccine

Medicare medical insurance helps pay for hepatitis B vaccine administered to beneficiaries considered to be at high or intermediate risk of contracting the disease.

Hemophilia Clotting Factors

Medicare medical insurance helps pay for blood clotting factors and items related to their administration for hemophilia patients who are able to use them to control bleeding without medical or other supervision. The amount of clotting factors necessary to have on hand for a specific period is determined for each patient individually.

Blood

Medicare medical insurance helps pay for blood and blood components you receive as a hospital outpatient or as part of other covered services, except for any nonreplacement fees charged for the first 3 pints or units received in each calendar year. After you have met the $75 annual deductible, medical insurance pays 80 percent of the approved charges for blood, starting with the fourth pint in a calendar year. If you have paid for or replaced blood under Medicare hospital insurance (Part A), you do not need to pay for or replace that blood again under Medicare medical insurance (Part B).

Antigens

Medicare medical insurance helps pay for antigens prepared by your doctor.

Immunosuppressive Drugs

Medicare medical insurance helps pay for drugs used in immunosuppressive therapy for one year beginning with the date of discharge from the inpatient hospital stay during which the Medicare-covered organ transplant was performed.

THE ASSIGNMENT PAYMENT METHOD

Under the assignment method, your doctor or supplier agrees to accept as total payment for services the charge approved by the Medicare carrier: the doctor or supplier agrees to "take assignment."

The assignment method can save you time and money. The doctor or supplier fills out your claim form and sends it to Medicare. Medicare pays your doctor or supplier 80 percent of the Medicare-approved charge, after subtracting any part of the $75 annual deductible you have not met. The doctor or supplier can charge you only for the part of the $75 annual deductible you have not met and for the coinsurance, which is the remaining 20 percent of the approved charge. Of course, your doctor or supplier also can charge you for services that Medicare does not cover.

If your doctor or supplier does not accept assignment, you may have to send in your claim

form yourself. Medicare pays you 80 percent of the approved charge, after subtracting any part of the $75 annual deductible you have not met. Many doctors that do not take assignment will fill out claim forms for patients. Ask your doctor if he or she provides this service.

For all Medicare medical insurance-covered services you get on or after September 1, 1990, a new rule will apply. All doctors and suppliers must fill out claim forms for you and send them to Medicare—whether or not they take assignment.

On or after April 1, 1990, doctors must take assignment on all claims for physician services furnished to Medicare beneficiaries who are eligible for medical assistance through their State Medicaid program, including qualified Medicare beneficiaries. (The qualified Medicare beneficiary program is discussed on page 5.)

PARTICIPATING DOCTORS AND SUPPLIERS

Doctors and suppliers may sign agreements to become Medicare-participating doctors or suppliers. This means that they have agreed in advance to accept assignment on all Medicare claims. Doctors and suppliers are given the opportunity to sign participation agreements each year. Medicare-participating doctors and suppliers can display emblems or certificates which show that they accept assignment on all Medicare claims.

The names and addresses of Medicare-participating doctors and suppliers are listed by geographic area in the "Medicare-Participating Physician/Supplier Directory." You can get the directory for your area free of charge from your Medicare carrier (see page 30); or you can call your carrier and ask for names of some participating doctors in your area. Also, this directory is available for review in Social Security offices, State and area offices of the Administration on Aging, and in most hospitals.

Many doctors and suppliers that do not take assignment on all claims, do take assignment on a case-by-case basis. They take assignment on some or most claims. Ask your doctor or supplier whether he or she will take assignment on your claims.

Below are examples of the two payment methods (in both examples, the $75 deductible has already been met).

PARTICIPATING PROVIDERS

Hospitals, skilled nursing facilities, home health agencies, comprehensive outpatient rehabilitation facilities, and providers of outpatient physical and occupational therapy and speech pathology services are all participating providers under Medicare medical insurance. They submit their claims directly to Medicare—you cannot submit claims for their services. Medicare subtracts any deductible you have not met and the coinsurance amount and pays the provider. The provider then bills you for only those deductible and coinsurance amounts.

EXPLANATION OF MEDICARE BENEFITS NOTICE

After you, the doctor, your provider, or your supplier sends in a medical insurance claim, Medicare will send you a notice called Explanation of Medicare Benefits to tell you the decision on the claim.

For services of a physician, this notice shows what services were covered, what charges were

	Actual Charge	Medicare Approved Charge	Medicare Pays	You Are Responsible For
Doctor Accepts Assignment	$500	$400	$320 (80% of approved charge)	$80 (20% approved charge)
*Doctor Does Not Accept Assignment	$500	$400	$320 (80% of approved charge)	$180 (difference between actual charge and Medicare payment)

*Medicare law requires doctors who do not take assignment for elective surgery to give you a written estimate of your out-of-pocket costs if the total charge is $500 or more. If the doctor does not give you this written estimate, you are entitled to a refund of any amount you paid him or her over the Medicare approved amount. There are also certain limits to charges of doctors who do not accept assignment.

approved, how much was credited toward your $75 annual deductible, and the amount Medicare paid. For other medical insurance services the notice shows similar information. Please examine the notice carefully. If you believe payment was made for a service or supply you didn't receive, or the payment is otherwise questionable, call or write the carrier that handled your claim.

The address and toll-free number you can use to contact your carrier is printed on the Explanation of Medicare Benefits form and on pages 30 to 34 of this handbook.

Many carriers have installed an automated telephone answering system to help make their response to you faster and more accurate. If your carrier has a system of this type, when you call you will be connected to a special automated voice system. If you have a touch-tone telephone, follow the instructions you receive over the phone to get information about the status of your claims.

If you need other information or want to talk about a claim, you can ask the system to connect you with a customer service representative at any time. If you do not have a touch-tone telephone, stay on the line after you dial and you will be connected to a customer service representative.

If you are enrolled in a prepaid health care organization, such as an HMO or CMP, you will seldom need to submit a claim. Medicare pays the HMO or CMP a set amount and the HMO or CMP provides your medical care. In most cases you are required to receive all non-emergency care through your HMO or CMP or through arrangements they make before you receive care. However, if you have a claim for an out-of-plan service, you should submit the claim directly to your HMO or CMP.

APPROVED OR "REASONABLE" CHARGES

Medicare medical insurance payments are based for the most part on what the law defines as "reasonable charges" or the amounts approved by the Medicare carrier. Because of the way the approved amounts are determined and because of high rates of inflation in medical care prices, the charges approved are often less than the actual charges billed by doctors and suppliers. Medical insurance usually pays only 80 percent of the approved charge even if it is less than the actual charge.

When you submit a medical insurance claim that is payable on a reasonable charge basis, the carrier compares the actual charge shown on the claim with the customary and prevailing charges for that service. The charge approved by the carrier will be the lowest of: 1) the customary charge (the charge most frequently made by the doctor or supplier for each item or service); or 2) the prevailing charge (based on all the customary charges in the locality for each type of service); or 3) the actual charge.

MEDICARE PAYMENTS FOR OUTPATIENT TREATMENT OF MENTAL ILLNESS

Medicare helps pay for services you receive for outpatient treatment of a mental illness. You may get the services from doctors, comprehensive outpatient rehabilitation facilities (CORFs), physician assistants and psychologists.

These services for outpatient treatment of a mental illness are subject to a special payment rule. In effect, Medicare pays only 50 percent (rather than 80 percent) of approved charges for these services, and beneficiaries are required to pay the remaining 50 percent.

Hospital outpatient treatment (including partial hospitalization psychiatric programs) of mental illness is not subject to this limit.

YOUR RIGHT OF APPEAL

If you disagree with a decision on the amount Medicare will pay on a claim or whether services you received are covered by Medicare, you have the right to appeal the decision. The notice you receive from Medicare which tells you of the decision made on a claim will also tell you exactly what appeal steps you can take. If you ever need more information about your right to appeal and how to request it, call Social Security, the Medicare intermediary or carrier, or the Peer Review Organization (PRO) in your State.
(Medicare carriers are listed on pages 30 to 34. PROs are listed on pages 35 to 38)

This section contains information on the following types of appeals:

* Appealing Decisions Made by Providers of Services on Your Medicare Hospital Insurance Claims 19
* Appealing Decisions Made by Peer Review Organizations (PROs) 19
* Appealing Decisions Made by Medicare Intermediaries on Your Hospital Insurance Claims 19
* Appealing Decisions Made by Medicare Carriers on Your Medical Insurance Claims 19

* Appealing Decisions by Health Maintenance Organizations (HMOs) or Competitive Medical Plans (CMPs) 20

APPEALING DECISIONS MADE BY PROVIDERS OF SERVICES ON YOUR MEDICARE HOSPITAL INSURANCE CLAIMS

In many cases the first written notice of noncoverage you receive will come from the provider of the services (for example, a hospital, skilled nursing facility, home health agency or hospice). This notice of noncoverage from the provider should explain why the provider believes Medicare will not pay for the services. This notice is not an official Medicare determination, but you can ask for an official Medicare determination. If you ask for an official Medicare determination, the provider must file a claim on your behalf to Medicare. When you receive the official Medicare determination, if you still disagree, you can appeal.

APPEALING DECISIONS MADE BY PEER REVIEW ORGANIZATIONS (PROs)

When you are admitted to a Medicare participating hospital, you will be given An Important Message From Medicare (see page 28 for a copy of the message). The message contains a brief description of PROs, and the name, address, and phone number of the PRO in your State. Also, it describes your appeal rights.

PROs make determinations about hospital care and ambulatory surgical center care. The PROs decide whether care provided to Medicare patients is medically necessary, provided in the most appropriate setting, and is of good quality. When you disagree with a PRO decision about your case, you can appeal by requesting a reconsideration. Then, if you disagree with the PRO's reconsideration decision, and the amount in question is $200 or more, you can request a hearing by an Administrative Law Judge. Cases involving $2,000 or more can eventually be appealed to a Federal Court.

NOTE: In the case of elective or non-emergency surgery, either the hospital or the PRO may be involved in pre-admission decisions. If the hospital believes that your proposed stay will not be covered by Medicare, it may recommend, without consulting the PRO, that you not be admitted to the hospital. If this is the case, the hospital must put its decision in writing. If you or your physician disagree with the hospital's decision, you should make a request to the PRO for immediate review. You must make your request, by telephone or in writing, within three calendar days after receipt of the notice.

APPEALING DECISIONS MADE BY INTERMEDIARIES ON YOUR MEDICARE HOSPITAL INSURANCE CLAIMS

Appeals of decisions on most other services covered under Medicare hospital insurance (skilled nursing facility care, home health care, hospice services, and a few inpatient hospital matters not handled by PROs) are handled by Medicare intermediaries. If you disagree with the intermediary's initial decision, you have 60 days from the date you receive the initial decision to request a reconsideration. The request can be submitted directly to the intermediary or through Social Security. If you disagree with the intermediary's reconsideration decision and the amount in question is $100 or more, you have 60 days from the date you receive the reconsideration decision to request a hearing by an Administrative Law Judge. Cases involving $1,000 or more can eventually be appealed to a Federal Court.

APPEALING DECISIONS MADE BY CARRIERS ON YOUR MEDICARE MEDICAL INSURANCE CLAIMS

Under Medicare medical insurance, either you, your doctor, or your supplier submits the claim for payment. (For services on or after September 1, 1990, your doctor, supplier, or other Medicare medical insurance provider of services must submit claims to Medicare for you. See page 22). Medicare will send you an explanation of the claim decision on a form called An Explanation of Medicare Benefits (EOMB). (See page 26 for a copy of this form.) The form also explains how you can appeal denials or payment decisions with which you disagree, and gives the name, address, and Statewide toll-free number of the carrier. (See also pages 30 to 34 for a list of carriers and the areas they serve.)

If your physician is a non-participating physician, he or she must provide you with a written notice in certain circumstances. If your physician knew or should have known that a particular service would not be considered reasonable and necessary under the Medicare program, he or she must give you written notice, before performing the service, of the reasons why he or she believes Medicare will not pay. This type of notice is not an official Medicare determination. If you receive the services in question, you may still submit a claim for

payment to Medicare. You then have the right to appeal the Medicare decision if you still disagree.

If you disagree with the decision on your claim, you have six months from the date of the decision to ask the carrier to review it. Then, if you disagree with the carrier's written explanation of its review decision and the amount in question is $100 or more, you have six months from the date of the review decision to request a hearing before a carrier hearing officer. (Generally, to reach the $100 amount, you can count other claims the carrier has reviewed within the past 6 months—if you disagree with the carrier's decision on them.)

If you disagree with the carrier hearing officer's decision and the amount in question is $500 or more, you have 60 days from the date you receive the decision to request a hearing before an Administrative Law Judge. Cases involving $1,000 or more can eventually be appealed to a Federal Court.

APPEALING DECISIONS MADE BY HEALTH MAINTENANCE ORGANIZATIONS (HMOs) AND COMPETITIVE MEDICAL PLANS (CMPs)

If you are a member of an HMO or CMP with a Medicare contract, decisions about coverage and payment for services will usually be made by your HMO/CMP. Your appeal rights are similar to the rights of Medicare beneficiaries under traditional fee-for-service Medicare. Also, Federal law requires HMOs and CMPs under contract to Medicare to provide a full, written explanation of appeal rights to all members at the time of enrollment, and at least once a year thereafter. If you are a member of an HMO or CMP and you have not received a written explanation of your appeal rights, you should request one from your organization's membership office.

WHAT MEDICARE DOES NOT PAY FOR

* Care That is Custodial 20
* Care That is Not Reasonable and Necessary under Medicare Program Standards 20
* Services Medicare Does Not Pay For ... 20
* Limit of Beneficiary Liability 20

CARE THAT IS CUSTODIAL

Medicare does not pay for custodial care. Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. Much of the care provided in nursing homes or by home agencies to persons with chronic, long-term illnesses or disabilities falls into this category. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine. Even if you are in a participating hospital or skilled nursing facility or you are receiving care from a participating home health agency, Medicare does not cover your care if it is mainly custodial.

CARE THAT IS NOT REASONABLE AND NECESSARY UNDER MEDICARE PROGRAM STANDARDS

Medicare does not pay for services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury. These services include drugs or devices that have not been approved by the Food and Drug Administration (FDA); medical procedures and services performed using drugs or devices not approved by FDA; and services, including drugs and devices, not considered safe and effective because they are experimental or investigational.

If a doctor places you in a hospital or skilled nursing facility when the kind of care you need could be provided elsewhere, your stay will not be considered reasonable and necessary. So Medicare will not pay for your stay. If you stay in a hospital or skilled nursing facility longer than you need to be there, Medicare payments will end when additional inpatient care is no longer reasonable and necessary.

If a doctor (or other practitioner) comes to treat you or you visit him or her for treatment more often than is medically necessary, Medicare will not pay for the "extra" visits. Medicare will not pay for more services than are reasonable and necessary for your treatment. Medicare always bases decisions about what is reasonable and necessary on professional medical advice.

SERVICES MEDICARE DOES NOT PAY FOR

Medicare, by law, cannot pay for certain services. These include services performed by immediate relatives or members of your household, and services by another government program. If you have a question about whether Medicare pays for a particular service, ask your Medicare carrier. (See pages 30 to 34 for the name and telephone number of your carrier.)

LIMITATION OF LIABILITY

Under Medicare law you will not be held responsible for payment of the cost of certain health care services for which you were denied

Medicare payment if you could not reasonably be expected to know that the services were not covered by Medicare. This provision is called limitation of liability and is often referred to as a "waiver of liability." This protection from financial liability applies only when the care was denied because it was:

(1) custodial care;
(2) not "reasonable and necessary" under Medicare program standards for diagnosis or treatment; or
(3) for home health services and the patient was not homebound or not receiving skilled nursing care on an intermittent basis.

This limitation of liability provision does not apply to Medicare medical insurance services provided by a non-participating physician, provider, or supplier unless he or she took assignment for the claim in question.

In certain situations Medicare law also protects you from liability for services provided by a non-participating physician denied as "not reasonable and necessary." If your physician knew or should have known that Medicare would not pay for a particular service, he or she must give you written notice—before performing the service—of the reasons why he or she believes Medicare will not pay. The physician must get your written agreement to pay for the services. If you did not receive this notice, you are not required to pay for the service. If you did pay, you may be entitled to a refund.

GETTING THE PART OF MEDICARE YOU DO NOT HAVE

This section tells you about:

* Getting Medical Insurance 21
* Getting Hospital Insurance 21
* Special Enrollment Period 21

GETTING MEDICARE MEDICAL INSURANCE

If you have Medicare premium-free hospital insurance but do not have the medical insurance part of Medicare, you can sign up for Medicare medical insurance during a general enrollment period. A general enrollment period is held January 1 through March 31 each year. Your protection will begin July 1 of the year you enroll. If you enroll during a general enrollment period, your monthly premium will be increased by 10 percent for each 12-month period you could have had Medicare medical insurance but were not enrolled.

GETTING MEDICARE HOSPITAL INSURANCE

Some people 65 or older have Medicare medical insurance, but do not meet the requirements for premium-free hospital insurance. Also, certain disabled people under age 65 will lose premium-free hospital insurance solely because they are working. If you are in either of these categories, you can get hospital insurance by paying a monthly premium. The hospital insurance premium is $175 a month through December 31, 1990. (This amount will change January 1, 1991.)

You can sign up for premium hospital insurance during a general enrollment period: January 1 through March 31 each year. If you enroll during a general enrollment period that begins more than one year after you became able to buy hospital insurance, your monthly premium will be 10 percent higher than the basic premium amount. Your protection will not begin until July 1 of the year you enroll.

For more information about premium amounts, premium surcharges, and how to get the part of Medicare you do not have, contact Social Security.

SPECIAL ENROLLMENT PERIOD

If you are covered by an employer health plan related to current employment, you may be able to delay enrollment in Medicare's medical insurance (or premium hospital insurance) without premium penalty and without waiting for a general enrollment period to enroll. Delayed enrollment without penalty or wait is available only if you are covered by an employer health plan at the time you were first able to get Medicare.

In general, if you are 65 or over, you may enroll in Medicare medical insurance (Part B) during the 7-month period beginning with the month you are no longer covered under the employer plan based on your employment or the employment of your spouse—even if the employer plan is not the primary payer. If you are disabled and covered by an employer health plan, you are also given a special enrollment period in certain circumstances. Certain disabled people who, when first able to get Medicare, are covered under a group health plan, may enroll in Medicare medical insurance during the 7-month period that begins when they are no longer covered under the plan, or when the plan is no longer classifiable as a large group health plan, or when the plan coverage is terminated.

Beginning July 1, 1990, disabled people who, since first becoming able to get Medicare, are covered under an employer group health plan of

any size, based on their own or their spouse's current employment, may also enroll during the 7-month special enrollment period after the plan ends, or the employment terminates, whichever occurs first.

Social Security can give you more information on special enrollment periods or delayed enrollment in Medicare's medical insurance.

EVENTS THAT CAN CHANGE YOUR MEDICARE PROTECTION

This section tells you about:

* When Protection Ends for Persons 65 and Older 22
* When Protection Ends for the Disabled 22
* When Protection Ends for those with Kidney Failure 22

WHEN PROTECTION ENDS FOR PERSONS 65 AND OLDER

If you have Medicare hospital insurance based on your husband's or wife's work record, your protection will end if you and your spouse divorce before your marriage has lasted 10 years. If you have hospital insurance based on your own work record, your protection will continue as long as you live.

Your Medicare medical insurance protection will stop if your premiums are not paid or if you voluntarily cancel. If you are thinking about cancelling your Medicare medical insurance, remember that you may not be able to get private insurance that offers the same protection. Also, if you cancel your Medicare medical insurance and then later decide to re-enroll, you can only re-enroll during a general enrollment period, your premium may be higher and your protection will not begin again until July 1 of the year you re-enroll (unless you qualify for a special enrollment period as described on page 21).

If you are buying Medicare hospital insurance as described previously, you will lose it if you cancel your Medicare medical insurance. People who buy hospital insurance must enroll and pay the premium for medical insurance. But, you can cancel hospital insurance and still continue to buy your medical insurance.

If you want more information about cancelling your Medicare protection, get in touch with Social Security.

WHEN PROTECTION ENDS FOR THE DISABLED

If you have Medicare because you are disabled, your protection will end if you recover from your disability before you are 65. If you go to work but are still disabled, your premium-free hospital insurance protection will continue for at least 48 months after you begin working. Your medical insurance will also continue for at least 48 months if you continue to pay the monthly premiums.

If you lose your premium-free hospital insurance, solely because you are working, you may elect to buy hospital and medical insurance for as long as you remain disabled. The first possible month you can buy insurance under this provision is July, 1990.

If you ever want to cancel the Medicare protection for which you pay premiums, get in touch with Social Security.

WHEN PROTECTION ENDS FOR THOSE WITH PERMANENT KIDNEY FAILURE

If you have Medicare because of permanent kidney failure, your protection will end 12 months after the month maintenance dialysis treatment stops or 36 months after the month you have a successful kidney transplant.

Your Medicare medical insurance protection could stop before that for failure to pay premiums or if you decide to cancel. Call Social Security if you ever want to cancel your medical insurance protection.

If you need more information about Medicare coverage of permanent kidney failure, you can get a copy of Medicare Coverage of Kidney Dialysis and Kidney Transplant Services from Social Security or the Consumer Information Center (see inside back cover).

HOW TO SUBMIT MEDICARE MEDICAL INSURANCE CLAIMS

This section will tell you about:

* A New Rule ..... see this page
* Submitting Your Claim 23
* When Other Insurance Pays First 23
* Submitting Claims For A Person Who Dies 24
* Time Limits 25
* Where To Send Your Claims 25

A NEW RULE

For services received on or after September 1, 1990, you do not have to submit

your medical insurance claims to Medicare. Your doctor, supplier, or other Medicare medical insurance provider of services must submit claims to Medicare for you. For services you receive before September 1, 1990, the following information will be useful.

SUBMITTING YOUR CLAIM

A Patient's Request for Medicare Payment form, also called Form 1490S (see page 26 for a sample form 1490S), must be submitted to the Medicare carrier for medical insurance to pay for covered services of doctors and suppliers. Medicare carriers, and most doctors' offices, have copies of the form. Instructions on how to fill it out are on the back of the form.

If the doctor or supplier is Medicare-participating, uses the assignment method of payment, or chooses to submit an unassigned claim for you, he or she submits the claim, and you do not have to use the 1490S form.

If the doctor or supplier does not accept assignment and does not submit the claim for you, you submit the claim, using the 1490S form. Complete and sign the form and attach itemized bills for the services you received.

An itemized bill must show:

- the date you received the services
- the place where you received the services
- a description of the services
- the charge for each service
- the doctor or supplier who provided the services
- your name and your health insurance claim number (including the letter at the end of the number).

If the bill doesn't include all of this information, your payment will be delayed. It is also helpful if the nature of your illness (diagnosis) is shown on the bill. If you are submitting a claim for the rental or purchase of durable medical equipment, you must include the bill from the supplier and the doctor's prescription. The prescription must show the equipment you need, the medical reason for the need, and an estimate of how long the equipment will be medically necessary.

You may submit several itemized bills with a 1490S form. It doesn't matter whether all the bills are from one doctor or supplier or from different people who gave you services. You can send in the bills either before or after you pay them.

Before any Medicare payment can be made, your record must show that you have met the deductible. So, as soon as your bills total $75 in 1990, send them to your Medicare carrier with a 1490S form. Page 25 tells you where to send your claim. Once you have met the $75 deductible, we suggest that you send in your future bills for covered services as soon as you get them so that Medicare payment can be made promptly.

If all your medical bills for the year amount to less than $75, Medicare medical insurance cannot pay any part of your bills for the year.

It's a good idea to keep a record of your medical insurance claim in case you ever want to inquire about it. Before you send in a claim, write down the date you mail it, the services you received, the date and charge for each service, and the name of the person who provided each service.

There are special rules for submitting your Medicare medical insurance claim if you are a member of an HMO or CMP. If you are a member of an HMO or CMP and you receive a bill for medical services, equipment or supplies, you should send the bill to your HMO or CMP for processing. You can find out who should process the claim by consulting your HMO/CMP membership handbook, or contacting your HMO/CMP.

Note The New Rule Above: Effective for services received on or after September 1, 1990, you do not have to submit your claims to Medicare. Your doctor, supplier, or other Medicare medical insurance provider of services must submit claims to Medicare for you.

WHEN OTHER INSURANCE PAYS FIRST

If any of the following insurance situations applies to you, please notify your doctor, hospital, or other provider of services and, except in the case of liability claims, file your claim with the other insurer first. Liability claims must be filed with Medicare first.

When You or Your Spouse Continue To Work

Medicare has special rules that apply to beneficiaries who have employer group health plan coverage through their employment or the employment of a spouse.

Employers with 20 or more employees are required to offer workers and their spouses age 65 and over the same health insurance benefits offered to younger workers and spouses. In such situations you and your spouse have the option to accept or reject your employer's health plan. If you accept it, Medicare will become the secondary payer. If you reject your employer's health plan, Medicare will remain the primary health insurance payer. If you elect Medicare to

be the primary payer, your employer cannot offer you coverage that supplements Medicare.

For more information, contact your employer or ask Social Security for a copy of Medicare and Employer Health Plans. The publication is also available from the Consumer Information Center (see inside back cover).

If You Are Disabled and Under Age 65

Medicare is the secondary payer for certain disabled people who have premium-free Medicare hospital insurance and are covered under an employer's health plan or the employer health plan of an employed family member. This secondary payer provision applies to group health plans of businesses that employ 100 or more people. Employees of smaller firms and their dependents may also be covered under certain conditions.

For more information, contact your employer or ask Social Security for a copy of Medicare and Employer Health Plans. The publication is also available from the Consumer Information Center (see inside back cover).

Other Situations Where Medicare is the Secondary Payer

If you have a work related illness or injury, services provided as treatment of that illness or injury should be covered by workers' compensation or Federal black lung benefits. It is important that your Medicare claim form note that the treatment is related to a work related illness or injury, even if the injury or illness occurred in the past.

Medicare is a secondary payer for up to one year for beneficiaries who have Medicare solely on the basis of End Stage Renal Disease (ESRD), if they have employer group health plan coverage.

Medicare also serves as the secondary payer in cases where no fault insurance or liability insurance is available as the primary payer.

Although Medicare benefits are secondary to benefits paid by liability insurers, you must file claims with Medicare first, and Medicare will make a conditional payment. When a liability settlement is reached, Medicare will recover its conditional payments from the settlement amount.

If You Have or Can Get Both Medicare and Veterans Benefits

If you have or can get both Medicare and veterans benefits, you may choose to get treatment under either program. But, Medicare:

- cannot pay for services you receive from VA hospitals or other VA facilities, except for certain emergency hospital services; and
- generally cannot pay if the VA pays for VA-authorized services that you get in a non-VA hospital or from a non-VA physician.

Medicare can pay for covered services you receive from non-VA hospitals and physicians if the VA has not authorized payment for the services. Since July 1986, the VA has been charging copayments to some veterans with non-service connected conditions for treatment in a VA hospital or medical facility, or for VA authorized treatment by non-VA sources. The VA charges copayments when the veteran's income exceeds a particular level. If the VA charges you a copayment for VA authorized care by a non-VA physician or hospital, Medicare may be able to reimburse you, in whole or in part, for your VA copayment obligation.

Note: Medicare cannot reimburse you for VA copayments for services furnished by VA hospitals and facilities, unless the services are emergency inpatient or outpatient hospital services. Then, the Medicare payment is subject to Medicare deductible and coinsurance amounts.

If you have questions about whether the VA or Medicare should pay for your doctor and other Medicare medical services, contact your Medicare carrier. If you have questions about whether the VA or Medicare should pay for hospital or other Medicare hospital insurance services, ask the provider of services to check with the Medicare intermediary.

SUBMITTING CLAIMS FOR A PERSON WHO DIES

When a Medicare beneficiary dies, any hospital insurance payments due will be paid directly to the hospital, skilled nursing facility, home health agency or hospice that provided covered services.

For services covered under Medicare medical insurance, some special rules apply, depending on whether the doctor's or supplier's bill has been paid.

If the bill was paid by the patient or with funds from the patient's estate, payment will be made either to the estate representative or to a surviving member of the patient's immediate family. If someone other than the patient paid the bill, payment may be made to that person.

If the bill has not been paid and the doctor or supplier does not accept assignment, the Medicare payment can be made to the person

who has legal obligation to pay the bill for the deceased patient. The person can claim the medical insurance payment either before or after paying the bill.

Your Medicare carrier can provide additional information about how to claim a medical insurance payment after a patient dies.

TIME LIMITS

Under the law, there are some time limits for submitting medical insurance claims. For medical insurance to make payments on your claims, you must send in your claims within these time limits. You always have at least 15 months to submit claims. The table below tells you exactly what the time limits are.

For service you receive between	Your claim must be submitted by
Oct 1, 1988, & Sept. 30, 1989	Dec. 31, 1990
Oct 1, 1989, & Sept. 30, 1990	Dec. 31, 1991
Oct 1, 1990, & Sept. 30, 1991	Dec. 31, 1992

WHERE TO SEND YOUR CLAIMS

The list on pages 30 to 34 gives the names, addresses, and telephone numbers, by State, of the Medicare carriers selected to handle claims. To find out where to send your Medicare medical insurance claim, look in the list for the State where you received the services.

Under the name of the State, you will find the name of the carrier that will handle your claim. If there is more than one carrier in the State, look for the county where you received services to find the carrier that will handle your claim. (See page 23 to find out how to submit claims.)

If you are not sure where to send your first claim and happen to send it to the wrong office, your claim will be sent to the right place.

Whenever you send in a claim, be sure to include the word "Medicare" in the carrier's address on the envelope. Also, be sure to put your return address and a stamp on the envelope.

After you make a claim, the carrier will usually send you another 1490S form for your next claim. The form will usually show the carrier's name and address in the top right hand corner. If you ever need to file a claim and don't have a claim form, you can use the one on page 26 or you can get one by calling your Medicare carrier.

NOTE: If you get Medicare under the Railroad Retirement system, send your medical insurance claims to The Travelers Insurance Company office which serves your region. Regional offices of The Travelers are listed in Your Medicare Handbook for Railroad Retirement Beneficiaries, which is available at any railroad retirement office.

[redacted]

FORM APPROVED
OMB NO. 0938-0008

PATIENT'S REQUEST FOR MEDICAL PAYMENT

IMPORTANT—SEE OTHER SIDE FOR INSTRUCTIONS

PLEASE TYPE OR PRINT INFORMATION — MEDICAL INSURANCE BENEFITS SOCIAL SECURITY ACT

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law. No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

1 Name of Beneficiary from Health Insurance Card (Last) (First) (Middle)

SEND COMPLETED FORM TO:

2 Claim Number from Health Insurance Card

Patient's Sex
☐ Male
☐ Female

3 Patient's Mailing Address (City, State, Zip Code)
Check here if this is a new address → ☐

(Street or P.O. Box — Include Apartment Number)

(City) (State) (Zip)

3b Telephone Number (Include Area Code)
(___ ___ ___)
___ ___ ___ – ___ ___ ___ ___

4 Describe the Illness or Injury for which Patient Received Treatment

4b Was condition related to:
A. Patient's employment ☐ Yes ☐ No
B. Accident ☐ Auto ☐ Other

4c Was patient being treated with chronic dialysis or kidney transplant?
☐ Yes ☐ No

5 a. Are you employed and covered under an employee health plan? ☐ Yes ☐ No

b. Is your spouse employed and are you covered under your spouse's employee health plan? ☐ Yes ☐ No

c. If you have any medical coverage other than Medicare, such as private insurance, employment related insurance, State Agency (Medicaid), or the VA, complete:
Name and Address of other insurance, State Agency (Medicaid), or VA office

Policy or Medical Assistance No.

Policyholders Name:

NOTE: If you DO NOT want payment information on this claim released, put an (X) here → ☐

6 I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO ME.

Signature of Patient (If patient is unable to sign, see Block 6 on reverse)

6b Date signed

IMPORTANT
ATTACH ITEMIZED BILLS FROM YOUR DOCTOR(S) OR SUPPLIER(S) TO THE BACK OF THIS FORM

Form HCFA-1490S (SC) (2-87) DEPARTMENT OF HEALTH AND HUMAN SERVICES—HEALTH CARE FINANCING ADMINISTRATION

HOW TO FILL OUT THIS MEDICARE FORM

Medicare will pay you directly when you complete this form and attach an itemized bill from your doctor or supplier. Your bill does not have to be paid before you submit this claim for payment, but you MUST attach an itemized bill in order for Medicare to process this claim.

FOLLOW THESE INSTRUCTIONS CAREFULLY:

A. Completion of this form.

Block 1. Print your name shown on your Medicare Card. (Last Name, First Name, Middle Name)

Block 2. Print your Health Insurance Claim Number including the letter at the end **exactly** as it is shown on your Medicare card. Check the appropriate box for the patient's sex.

Block 3. Furnish your mailing address and include your telephone number in Block 3b.

Block 4. Describe the illness or injury for which you received treatment. Check the appropriate box in Blocks 4b and 4c.

Block 5a. Complete this Block if you are age 65 or older and enrolled in a health insurance plan where you are currently working.

Block 5b. Complete this Block if you are age 65 or older and enrolled in a health insurance plan where your spouse is currently working.

Block 5c. Complete this Block if you have any medical coverage other than Medicare. Be sure to provide the Policy or Medical Assistance Number. You may check the box provided if you do not wish payment information from this claim released to your other insurer.

Block 6. Be sure to sign your name. If you cannot write your name, make an (X) mark. Then have a witness sign his or her name and address in Block 6 too.

If you are completing this form for another Medicare patient you should write (By) and sign your name and address in Block 6. You also should show your relationship to the patient and briefly explain why the patient cannot sign.

Block 6b. Print the date you completed this form.

B. Each itemized bill MUST show all of the following information:

- Date of each service
- Place of each service —Doctor's Office —Independent Laboratory —Outpatient Hospital —Nursing Home —Patient's Home —Inpatient Hospital
- Description of each surgical or medical service or supply furnished.
- Charge for EACH service.
- Doctor's or supplier's name and address. Many times a bill will show the names of several doctors or suppliers. IT IS VERY IMPORTANT THE ONE WHO TREATED YOU BE IDENTIFIED. Simply circle his/her name on the bill.
- It is helpful if the diagnosis is shown on the physician's bill. If not, be sure you have completed Block 4 of this form.
- Mark out any services on the bill(s) you are attaching for which you have already filed a Medicare claim.
- If the patient is deceased please contact your Social Security office for instructions on how to file a claim.
- Attach an Explanation of Medicare Benefits notice from the other insurer if you are also requesting Medicare payment.

COLLECTION AND USE OF MEDICARE INFORMATION

We are authorized by the Health Care Financing Administration to ask you for information needed in the administration of the Medicare program. Authority to collect information is in section 205 (a), 1872 and 1875 of the Social Security Act, as amended.

The information we obtain to complete your Medicare claim is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations as necessary to administer the Medicare program. For example, it may be necessary to disclose information about the Medicare benefits you have used to a hospital or doctor.

With one exception, which is discussed below, there are no penalties under social security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of the claim. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether worker's compensation will pay for the treatment. Section 1877 (a) (3) of the Social Security Act provides criminal penalties for withholding this information.

Public reporting burden for this collection of information is estimated to average 16 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to HCFA, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

AN IMPORTANT MESSAGE FROM MEDICARE

YOUR RIGHTS WHILE YOU ARE A MEDICARE HOSPITAL PATIENT

- You have the right to receive all the hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. According to Federal law, **your discharge date must be determined solely by your medical needs**, not by "DRGs" or Medicare payments.

- You have the right to be fully informed about decisions affecting your Medicare coverage and payment for your hospital stay and for any post-hospital services.

- You have the right to request a review by a Peer Review Organization of any written Notice of Noncoverage that you receive from the hospital stating that Medicare will no longer pay for your hospital care. Peer Review Organizations (PROs) are groups of doctors who are paid by the Federal Government to review medical necessity, appropriateness and quality of hospital treatment furnished to Medicare patients. The phone number and address of the PRO for your area are:

  _____

  _____

  _____

TALK TO YOUR DOCTOR ABOUT YOUR STAY IN THE HOSPITAL

You and your doctor know more about your condition and your health needs than anyone else. Decisions about your medical treatment should be made between you and your doctor. **If you have any questions about your medical treatment, your need for continued hospital care, your discharge, or your need for possible post-hospital care, don't hesitate to ask your doctor.** The hospital's patient representative or social worker will also help you with your questions and concerns about hospital services.

IF YOU THINK YOU ARE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON

- Ask a hospital representative for a written notice of explanation immediately, if you have not already received one. This notice is called a "Notice of Noncoverage." You must have this Notice of Noncoverage if you wish to exercise your right to request a review by the PRO.

- The Notice of Noncoverage will state either that your doctor or the PRO agrees with the hospital's decision that Medicare will no longer pay for your hospital care.

  + If the hospital and your doctor agree, the PRO does not review your case before a Notice of Noncoverage is issued. But the PRO will respond to your request for a review of your Notice of Noncoverage and seek your opinion. You cannot be made to pay for your hospital care until the PRO makes its decision, if you request the review by noon of the first work day after you receive the Notice of Noncoverage.

  + If the hospital and your doctor disagree, the hospital may request the PRO to review your case. If it does make such a request, the hospital is required to send you a notice to that effect. In this situation the PRO must agree with the hospital or the hospital cannot issue a Notice of Noncoverage. You may request that the PRO reconsider your case after you receive a Notice of Noncoverage but since the PRO has already reviewed your case once, you may have to pay for **at least one day of hospital care** before the PRO completes this reconsideration.

IF YOU **DO NOT** REQUEST A REVIEW, **THE HOSPITAL MAY BILL YOU** FOR ALL THE COSTS OF YOUR STAY BEGINNING WITH THE THIRD DAY AFTER YOU RECEIVE THE NOTICE OF NONCOVERAGE. THE HOSPITAL, HOWEVER, CANNOT CHARGE YOU FOR CARE UNLESS IT PROVIDES YOU WITH A NOTICE OF NONCOVERAGE.

HOW TO REQUEST A REVIEW OF THE NOTICE OF NONCOVERAGE

- If the Notice of Noncoverage states that your **physician agrees** with the hospital's decision:
  - + You must make your request for review to the PRO by **noon of the first work day** after you receive the Notice of Noncoverage by contacting the PRO by phone or in writing.
  - + The PRO must ask for your views about your case before making its decision. The PRO will inform you by phone and in writing of its decision on the review.
  - + If the PRO agrees with the Notice of Noncoverage, you may be billed for all costs of your stay beginning at noon of the day after you receive the PRO's decision.
  - + Thus, you will not be responsible for the cost of hospital care before you receive the PRO's decision.
- If the Notice of Noncoverage states that the **PRO agrees** with the hospital's decision:
  - + You should make your request for reconsideration to the PRO **immediately** upon receipt of the Notice of Noncoverage by contacting the PRO by phone or in writing.
  - + The PRO can take up to three working days from receipt of your request to complete the review. The PRO will inform you in writing of its decision on the review.
  - + Since the PRO has already reviewed your case once, prior to the issuance of the Notice of Noncoverage, the hospital is permitted to begin billing you for the cost of your stay beginning with the third calendar day after you receive your Notice of Noncoverage **even if the PRO has not completed its review.**
  - + Thus, if the PRO continues to agree with the Notice of Noncoverage, **you may have to pay for at least one day of hospital care.**

NOTE: The process described above is called "immediate review." If you miss the deadline for this immediate review while you are in the hospital, you may still request a review of Medicare's decision to no longer pay for your care at any point during your hospital stay or after you have left the hospital. The Notice of Noncoverage will tell you how to request this review.

POST-HOSPITAL CARE

When your doctor determines that you no longer need all the specialized services provided in a hospital, but you still require medical care, he or she may discharge you to a skilled nursing facility or home care. The discharge planner at the hospital will help arrange for the services you may need after your discharge. Medicare and supplemental insurance policies have limited coverage for skilled nursing facility care and home health care. Therefore, you should find out which services will or will not be covered and how payment will be made. Consult with your doctor, hospital discharge planner, patient representative and your family in making preparations for care after you leave the hospital. **Don't hesitate to ask questions.**

ACKNOWLEDGEMENT OF RECEIPT-My signature only acknowledges my receipt of this Message from (name of hospital) on (date) and does not waive any of my rights to request a review or make me liable for any payment.

_____

Signature of beneficiary or
person acting on behalf of beneficiary

MEDICARE CARRIERS

Note: The toll-free or 800 numbers listed below can be used only in the states where the carriers are located. Also listed are the local commercial numbers for the carriers. Out of State callers must use the commercial numbers. Many carriers have installed an automated telephone answering system. If you have a touch-tone telephone, you can follow the system instructions to find out about your latest claims and get other information. If you do not have a touch-tone telephone, stay on the line and someone will help you.

ALABAMA
Medicare/Blue Cross-Blue Shield of Alabama
P.O. Box C-140
Birmingham, Alabama 35283
1-800-292-8855
205-988-2244

ALASKA
Medicare/Aetna Life & Casualty
200 S.W. Market St., P.O. Box 1998
Portland, Oregon 97207-1998
1-800-547-6333
503-222-6831 (customer service site actually in Oregon)

ARIZONA
Medicare/Aetna Life & Casualty
P.O. Box 37200
Phoenix, Arizona 85069
1-800-352-0411
602-861-1968

ARKANSAS
Medicare/Arkansas Blue Cross and Blue Shield
A Mutual Insurance Company
P.O. Box 1418
Little Rock, Arkansas 72203
1-800-482-5525
501-378-2320

CALIFORNIA
Counties of: Los Angeles, Orange, San Diego, Ventura, Imperial, San Luis Obispo, Santa Barbara
Medicare/Transamerica Occidental Life Insurance Co.
Box 50061
Upland, California 91785-0061
1-800-252-9020
213-748-2311
Rest of State: Medicare Claims Dept.
Blue Shield of California
Chico, California 95976
(In area codes 209, 408,415, 707, 916)
1-800-952-8627
916-743-1583
(In the following area codes—[**other than Los Angeles, Orange, San Diego, Ventura, Imperial, San Luis Obispo, and Santa Barbara counties**]— 213, 619, 714, 805, 818)
1-800-848-7713
714-824-0900

COLORADO
Medicare/Blue Shield of Colorado
700 Broadway
Denver, Colorado 80273
1-800-332-6681
303-831-2661

CONNECTICUT
Medicare/The Travelers Ins. Co.
538 Preston Avenue
P.O. Box 9000
Meriden, Connecticut 06454-9000
1-800-982-6819
(In Hartford) 203-728-6783
(In the Meriden area) 203-237-8592

DELAWARE
Medicare/Pennsylvania Blue Shield
P.O. Box 890200
Camp Hill, Pennsylvania 17089-0200
1-800-851-3535

DISTRICT OF COLUMBIA
Medicare/Pennsylvania Blue Shield
P.O. Box 890100
Camp Hill, Pennsylvania 17089-0100
1-800-233-1124

FLORIDA
Medicare/Blue Shield of Florida, Inc.
P.O. Box 2525
Jacksonville, Florida 32231
For fast service on simple inquiries including requests for copies of Explanation of Medicare Benefits notices, requests for Medpard directories, brief claims inquiries (status or verification of receipt), and address changes:
1-800-666-7586
For all your other Medicare needs:
1-800-333-7586
904-355-3680

GEORGIA
Medicare/Aetna Life & Casualty
P.O. Box 3018
Savannah, Georgia 31402-3018
1-800-727-0827
912-920-2412

HAWAII
Medicare/Aetna Life & Casualty
P.O. Box 3947
Honolulu, Hawaii 96812
1-800-272-5242
808-524-1240

IDAHO
EQUICOR, Inc.
3150 N. Lakeharbor Lane, Suite 254
P.O. Box 8048
Boise, Idaho 83703-6219
1-800-627-2782
208-342-7763

ILLINOIS
Medicare Claims
Blue Cross & Blue Shield of Illinois
P.O. Box 4422
Marion, Illinois 62959
1-800-642-6930
312-938-8000

INDIANA
Medicare Part B
Associated Ins. Companies, Inc.
P.O. Box 7073
Indianapolis, Indiana 46207
1-800-622-4792
317-842-4151

IOWA
Medicare
IASD Health Services Inc.
(d/b/a Blue Cross & Blue Shield of Iowa)
636 Grand
Des Moines, Iowa 50309
1-800-532-1285
515-245-4785

KANSAS
Counties of: Johnson, Wyandotte
Medicare/Blue Shield of Kansas City
P.O. Box 169
Kansas City, Missouri 64141
1-800-892-5900
816-561-0900
Rest of State: Medicare/Blue Shield of Kansas
P.O. Box 239
Topeka, Kansas 66601
1-800-432-3531
913-232-3773

KENTUCKY
Medicare-Part B
Blue Cross & Blue Shield of Kentucky
100 East Vine St.
Lexington, Kentucky 40507
1-800-999-7608
606-233-1441

LOUISIANA
Arkansas Blue Cross & Blue Shield
Medicare Administration
P.O. Box 95024
Baton Rouge, Louisiana 70895-9024
1-800-462-9666
(In New Orleans) 504-529-1494
(In Baton Rouge) 504-272-1242

MAINE
Medicare/Blue Shield of
Massachusetts/Tri-State
P.O. Box 1010
Biddeford, Maine 04005
1-800-492-0919
207-282-5991

MARYLAND
Counties of: Montgomery, Prince Georges
Medicare/Pennsylvania Blue Shield
P.O. Box 890100
Camp Hill, Pennsylvania 17089-0100
1-800-233-1124
Rest of State: Maryland Blue Shield, Inc.
700 E. Joppa Road
Towson, Maryland 21204
1-800-492-4795
301-561-4160

MASSACHUSETTS
Medicare/Blue Shield of Massachusetts, Inc.
1022 Hingham Street
Rockland, Massachusetts 02371
1-800-882-1228
617-956-3994

MICHIGAN
Medicare Part B
Michigan Blue Cross & Blue Shield
P.O. Box 2201, Detroit, Michigan 48231-2201
(In area code 313) 1-800-482-4045
(In area code 517) 1-800-322-0607
(In area code 616) 1-800-442-8020
(In area code 906) 1-800-562-7802
(In Detroit) 313-225-8200

MINNESOTA
Counties of: Anoka, Dakota, Filmore, Goodhue, Hennepin, Houston, Olmstead, Ramsey, Wabasha, Washington, Winona
Medicare/The Travelers Ins. Co.
8120 Penn Avenue South
Bloomington, Minnesota 55431
1-800-352-2762
612-884-7171
Rest of State: Medicare
Blue Shield of Minnesota
P.O. Box 64357
St. Paul, Minnesota 55164
1-800-392-0343
612-456-5070

MISSISSIPPI
Medicare/The Travelers Ins. Co.
P.O. Box 22545
Jackson, Mississippi 39225-2545
(In Mississippi) 1-800-682-5417
(Outside Mississippi) 1-800-227-2349
601-956-0372

MISSOURI
Counties of: Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, St. Clair, Saline, Vernon, Worth
Medicare/Blue Shield of Kansas City
P.O. Box 169
Kansas City, Missouri 64141
1-800-892-5900
816-561-0900
Rest of State: Medicare
General American Life Insurance Co.
P.O. Box 505
St. Louis, Missouri 63166
1-800-392-3070
314-843-8880

MONTANA
Medicare
Blue Shield of Montana, Inc.
2501 Beltview
P.O. Box 4310
Helena, Montana 59604
1-800-332-6146
406-444-8350

NEBRASKA
The carrier for Nebraska is Blue Shield of Kansas. Claims, however, should be sent to:
Medicare Part B
Blue Cross/Blue Shield of Nebraska
P.O. Box 3106
Omaha, Nebraska 68103-0106
1-800-633-1113
913-232-3773 (customer service site in Kansas)

NEVADA
Medicare/Aetna Life and Casualty
P.O. Box 37230
Phoenix, Arizona 85069
1-800-528-0311
602-861-1968

NEW HAMPSHIRE
Medicare
Blue Shield of Massachusetts/Tri-State
P.O. Box 1010
Biddeford, Maine 04005
1-800-447-1142
207-282-5991

NEW JERSEY
Medicare/Pennsylvania Blue Shield
P.O. Box 400010
Harrisburg, Pennsylvania 17140-0010
1-800-462-9306

NEW MEXICO
Medicare/Aetna Life and Casualty
P.O. Box 25500
Oklahoma City, Oklahoma 73125-0500
1-800-423-2925
(In Albuquerque) 505-843-7771

NEW YORK
Counties of: Bronx, Kings, New York, Richmond
Medicare/Empire Blue Cross and Blue Shield
P.O. Box 100
Yorktown Heights, New York 10598
212-490-4444
Counties of: Columbia, Delaware, Dutchess, Greene, Nassau, Orange, Putnam, Rockland, Suffolk, Sullivan, Ulster, Westchester
Medicare/Empire Blue Cross and Blue Shield
P.O. Box 100
Yorktown Heights, New York 10598
1-800-442-8430
212-490-4444
County of: Queens
Medicare/Group Health, Inc.
P.O. Box 1608, Ansonia Station
New York, New York 10023
212-721-1770
Rest of State: Medicare
Blue Shield of Western New York
P.O. Box 5600
Binghamton, New York 13902-0600

607-772-6906
1-800-252-6550

NORTH CAROLINA
EQUICOR, Inc.
P.O. Box 671
Nashville, Tennessee 37202
1-800-672-3071
919-665-0348

NORTH DAKOTA
Medicare/Blue Shield of North Dakota
4510 13th Avenue, S.W.
Fargo, North Dakota 58121-0001
1-800-247-2267
701-282-1100

OHIO
Medicare/Nationwide Mutual Ins. Co.
P.O. Box 57
Columbus, Ohio 43216
1-800-282-0530
614-249-7157

OKLAHOMA
Medicare/Aetna Life and Casualty
701 N.W. 63rd St., Suite 100
Oklahoma City, Oklahoma 73116-7693
1-800-522-9079
405-848-7711

OREGON
Medicare/Aetna Life and Casualty
200 S.W. Market St.
P.O. Box 1997
Portland, Oregon 97207-1997
1-800-452-0125
503-222-6831

PENNSYLVANIA
Medicare/Pennsylvania Blue Shield
P.O. Box 890065
Camp Hill, Pennsylvania 17089-0065
1-800-382-1274

RHODE ISLAND
Medicare/Blue Shield of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901
1-800-662-5170
401-861-2273

SOUTH CAROLINA
Medicare Part B
Blue Cross and Blue Shield of South Carolina
Fontaine Road Business Center
300 Arbor Lake Drive, Suite 1300
Columbia, South Carolina 29223
1-800-868-2522
803-754-0639

SOUTH DAKOTA
Medicare Part B
Blue Shield of North Dakota
4510 13th Avenue, S.W.
Fargo, North Dakota 58121-0001
1-800-437-4762
701-282-1100

TENNESSEE
EQUICOR, Inc.
P.O. Box 1465
Nashville, Tennessee 37202
1-800-342-8900
615-244-5650

TEXAS
Medicare
Blue Cross & Blue Shield of Texas, Inc.
P.O. Box 660031
Dallas, Texas 75266-0031
1-800-442-2620
214-235-3433

UTAH
Medicare/Blue Shield of Utah
P.O. Box 30269
Salt Lake City, Utah 84130-0269
1-800-426-3477
801-481-6196

VERMONT
Medicare
Blue Shield of Massachusetts/Tri-State
P.O. Box 1010
Biddeford, Maine 04005
1-800-447-1142
207-282-5991

VIRGINIA
Counties of: Arlington, Fairfax;
Cities of: Alexandria, Falls Church, Fairfax
Medicare/Pennsylvania Blue Shield
P.O. Box 890100
Camp Hill, Pennsylvania 17089-0100
1-800-233-1124
Rest of State: Medicare/The Travelers Ins. Co.
P.O. Box 26463
Richmond, Virginia 23261
1-800-552-3423
804-254-4130

WASHINGTON
Medicare/Washington Physicians' Service
Mail to your local Medical Service Bureau.
If you do not know which bureau handles your claim, mail to:
Medicare Washington Physicians' Service
4th and Battery Bldg., 6th Floor
2401 4th Avenue
Seattle, Washington 98121
(In King County) 1-800-422-4087
206-464-3711
(In Spokane) 1-800-572-5256
509-536-4550
(In Kitsap) 1-800-552-7114
206-377-5576
(In Pierce) 206-597-6530
(In Thurston) 206-352-2269
Others: Collect if out of call area.

WEST VIRGINIA
Medicare/Nationwide Mutual Insurance Co.
P.O. Box 57
Columbus, Ohio 43216
1-800-848-0106
614-249-7157

WISCONSIN
Medicare/WPS
Box 1787
Madison, Wisconsin 53701
1-800-362-7221
(In Madison) 608-221-3330
(In Milwaukee) 414-931-1071

WYOMING
Blue Cross/Blue Shield of Wyoming
P.O. Box 628
102 Indian Hills Shpg. Cntr.
Cheyenne, Wyoming 82003
1-800-442-2371
307-632-9381

AMERICAN SAMOA
Medicare/Hawaii Medical Services Assn.
P.O. Box 860
Honolulu, Hawaii 96808
808-944-2247

GUAM
Medicare/Aetna Life and Casualty
P.O. Box 3947
Honolulu, Hawaii 96812
808-524-1240

NORTHERN MARIANA ISLANDS
Medicare/Aetna Life & Casualty
P.O. Box 3947
Honolulu, Hawaii 96812
808-524-1240

PUERTO RICO
Medicare/Seguros De Servicio De Salud De Puerto Rico
Call Box 71391
San Juan, Puerto Rico 00936
800-462-7015
809-749-4900

VIRGIN ISLANDS
Medicare/Seguros De Servicio De Salud De Puerto Rico
Call Box 71391
San Juan, Puerto Rico 00936
(In St. Croix) 809-778-2665
(In St. Thomas) 809-774-3898

MEDICARE PEER REVIEW ORGANIZATIONS (PROs) AND QUALITY REVIEW ORGANIZATIONS (QROs)

*** Designates States where the PRO is also the QRO**

ALABAMA*
Alabama Quality Assurance Foundation
Suite 600
600 Beacon Parkway West
Birmingham, AL 35209-3154
205-942-0785

ALASKA
Professional Review Organization for
Washington (PRO for Alaska)
Suite 300
10700 Meridian Avenue, North
Seattle, WA 98133
206-364-9700

AMERICAN SAMOA/GUAM
Hawaii Medical Services Association
for American Samoa/Guam
818 Keeaumoku Street
P.O. Box 860
Honolulu, HI 96808
808-944-2173

ARIZONA*
Health Services Advisory Group, Inc
301 East Bethany Home Road
Suite 157, Bldg. B
P.O. Box 16731
Phoenix, AZ 85012
602-264-6382

ARKANSAS
Arkansas Foundation for
Medical Care, Inc.
P.O. Box 1508
809 Garrison Avenue
Fort Smith, AR 72902
501-785-2471

CALIFORNIA*
California Medical Review Inc.
Suite 500
60 Spear Street
San Francisco, CA 94105
415-882-5800

COLORADO*
Colorado Foundation for Medical Care
1260 South Parker Road
P.O. Box 1730
Denver, CO 80231-2179
303-321-8642

CONNECTICUT*
Connecticut Peer Review Organization, Inc.
100 Roscommon Drive
Middletown, CT 06457
203-632-2008

DELAWARE
West Virginia Medical Institute, Inc.
(PRO for Delaware)
3412 Chesterfield Ave. S.E.
Charleston, WV 25304
304-925-0461

DISTRICT OF COLUMBIA
Delmarva Foundation for
Medical Care, Inc.
(PRO for D.C.)
341 B North Aurora Street
Easton, MD 21601
301-822-0697

FLORIDA*
Professional Foundation for
Health Care, Inc.
Suite 100
2907 Bay to Bay Blvd.
Tampa, FL 33629
813-831-6273

GEORGIA*
Georgia Medical Care Foundation
Suite 1300
4 Executive Park Drive, N.E.
Atlanta, GA 30329
404-982-0411

HAWAII
Hawaii Medical Services Association
818 Keeaumoku Street
P.O. Box 860
Honolulu, HI 96808
808-944-3581

IDAHO
Professional Review Organization for
Washington (PRO for Idaho)
Suite 300
10700 Meridian Avenue, North
Seattle, WA 98133
206-364-9700

ILLINOIS*
Crescent Counties Foundation for Medical Care
350 Shuman Boulevard
Suite 240
Naperville, IL 60540
312-357-8770

INDIANA*
Sentinal Medical Review Organization
2901 Ohio Boulevard
P.O. Box 3713
Terre Haute, IN 47803
812-234-1499

IOWA*
Iowa Foundation for Medical Care
Colony Park, Suite 500
3737 Woodland Avenue
West Des Moines, IA 50265
515-223-2900

KANSAS*
The Kansas Foundation for Medical Care, Inc.
2947 SW. Wanamaker Drive
Topeka, KS 66614
913-273-2552

KENTUCKY*
Sentinal Medical Review Organization
10503 Timberwood Circle, Suite 200
P.O. Box 23540
Louisville, KY 40223
502-339-7442

LOUISIANA
Louisiana Health Care Review
9357 Interline Avenue, Suite 200
Baton Rouge, LA 70809
504-926-6353

MAINE
Health Care Review, Inc. (PRO for Maine)
Henry C. Hall Building
345 Blackstone Blvd.
Providence, RI 02906
401-331-6661

MARYLAND*
Delmarva Foundation for Medical Care, Inc.
(PRO for Maryland)
341 B North Aurora Street
Easton, MD 21601
301-822-0697

MASSACHUSETTS*
Massachusetts Peer Review Organization, Inc.
300 Bearhill Road
Waltham, MA 02154
617-890-0011

MICHIGAN*
Michigan Peer Review Organization
40500 Ann Arbor Road, Suite 200
Plymouth, MI 48170
313-459-0900

MINNESOTA*
Foundation for Health Care Evaluation
Suite 700
One Appletree Square
Minneapolis, MN 55425
612-854-3306

MISSISSIPPI
Mississippi Foundation for Medical Care, Inc.
P.O. Box 4665
735 Riverside Drive
Jackson, MS 39296-4665

MISSOURI
Quality Quest
(QRO for Missouri)
One Appletree Square
Suite 700
Minneapolis, MN 55420
612-853-8599

Missouri Patient Care Review Foundation
(PRO for Missouri)
505 Hobbes Lane
Suite 100
Jefferson City, MO 65109
314-893-7900

MONTANA
Montana-Wyoming Foundation for Medical Care
P.O. Box 5117
21 North Main
Helena, MT 59601
406-443-4020

NEBRASKA*
Iowa Foundation for Medical Care
(PRO for Nebraska)
Colony Park Building, Suite 500
3737 Woodland Avenue
West Des Moines, IA 50265
515-223-2900

NEVADA*
Utah Peer Review Organization
(PRO/QRO for Nevada)
675 East 2100 South
Salt Lake City, UT 84106-1864
801-487-2290

NEW HAMPSHIRE
New Hampshire Foundation for
Medical Care
P.O. Box 578
110 Locust Street
Dover, NH 03820
603-749-1641

NEW JERSEY*
The Peer Review Organization of
New Jersey, Inc.
Central Division
Brier Hill Court, Building J
East Brunswick, NJ 08816
201-238-5570

NEW MEXICO*
New Mexico Medical Review Association
707 Broadway N.E., Suite 200
P.O. Box 9900
Albuquerque, NM 87119-9900
505-842-6236

NEW YORK
Island Peer Review Organization
9525 Queens Blvd.
10th Floor
Rego Park, NY 11374-4511
718-896-7230

NORTH CAROLINA*
Medical Review of North Carolina
Suite 200
P.O. Box 37309
1011 Schaub Drive
Raleigh, NC 27627
919-851-2955

NORTH DAKOTA
North Dakota Health Care Review, Inc.
Suite 301
900 North Broadway
Minot, ND 58701
701-852-4231

OHIO*
Peer Review Systems, Inc.
3700 Corporate Drive, Suite 250
Columbus, OH 43231-4996
614-895-9900

OKLAHOMA*
Oklahoma Foundation for Peer Review, Inc.
Suite 400 The Paragon Building
5801 Broadway Extension
Oklahoma City, OK 73118
405-840-2891

OREGON*
Oregon Medical Professional Review
Organization
Suite 300
1220 Southwest Morrison
Portland, OR 97205
503-279-0100

PENNSYLVANIA*
Keystone Peer Review Organization, Inc.
777 East Park Drive
P.O. Box 8310
Harrisburg, PA 17105-8310
717-564-8288

PUERTO RICO
Puerto Rico Foundation for Medical Care
Suite 605 Mercantile Plaza
Hato Rey, PR 00918
809-753-6705

RHODE ISLAND*
Health Care Review, Inc.
Henry C. Hall Building
345 Blackstone Boulevard
Providence, RI 02906
401-331-6661

SOUTH CAROLINA
Medical Review of North Carolina
(PRO for South Carolina)
P.O. Box 37309
1011 Schaub Drive, Suite 200
Raleigh, NC 27627
919-851-2955

SOUTH DAKOTA
South Dakota Foundation for Medical Care
1323 South Minnesota Avenue
Sioux Falls, SD 57105
605-336-3505

TENNESSEE
Mid-South Foundation for Medical Care
Suite 400
6401 Poplar Avenue
Memphis, TN 38119
901-682-0381

TEXAS*
Texas Medical Foundation
Barton Oaks Plaza Two, Suite 200
901 Mopac Expressway South
Austin, TX 78746
512-329-6610

UTAH
Utah Peer Review Organization
675 East 2100 South
Suite 270
Salt Lake City, UT 84106
801-487-2290

VERMONT
New Hampshire Foundation for Medical Care
(PRO for Vermont)
P.O. Box 578
110 Locust Street
Dover, NH 03820
603-749-1641

VIRGIN ISLANDS
Virgin Islands Medical Institute
P.O. Box 1556
Christiansted
St. Croix, U.S.A. VI 00820
809-778-6470

VIRGINIA
Medical Society of Virginia Review Organization
1606 Santa Rosa Road, Suite 235
P.O. Box K 70
Richmond, VA 23288
804-289-5320

WASHINGTON*
Professional Review Organization for
Washington
Suite 300
10700 Meridian Avenue, North
Seattle, WA 98133-9075
206-364-9700

WEST VIRGINIA
West Virginia Medical Institute, Inc.
3412 Chesterfield Avenue, S.E.
Charleston, WV 25304
304-925-0461

WISCONSIN*
Wisconsin Peer Review Organization
2001 W. Beltline Highway
Madison, WI 53713
608-274-1940

WYOMING
Montana-Wyoming Foundation for Medical Care
P.O. Box 5117
21 North Main
Helena, MT 59601
406-443-4020

GLOSSARY OF MEDICARE-RELATED TERMS

actual charge — the amount a physician or supplier actually bills a patient for a particular medical service or supply. (This may differ from the customary, prevailing, and/or reasonable charges under Medicare.)

assignment — a process through which a doctor or supplier agrees to accept the Medicare program's payment as payment in full except for specific coinsurance and deductible amounts required of the patient.

carrier — a private insurance organization that contracts with the Federal government to handle claims from doctors and suppliers of services covered by Medicare medical insurance.

claim — a request to a carrier or intermediary by a beneficiary or a provider acting on behalf of a beneficiary for payment of benefits under Medicare.

coinsurance — a cost-sharing requirement that a beneficiary will assume a portion or percentage of the costs of covered services.

competitive medical plan (CMP) — an organization that provides a full range of health care coverage in exchange for a monthly, fixed fee. CMPs with Medicare contracts offer Medicare beneficiaries all services covered by fee-for-service Medicare. Medicare pays these plans on a monthly basis for each Medicare beneficiary. Medicare beneficiaries get all Medicare-covered hospital and medical insurance benefits through the plan. The CMP may also collect a premium from each Medicare member enrolled in the plan.

custodial care — treatment or services, regardless of who recommends them or where they are provided, that could be given safely and reasonably by a person not medically skilled, and are designed mainly to help the patient with daily living. Examples include help with walking, bathing, dressing, and using the toilet.

customary charge — the amount a doctor or supplier most frequently charges for each separate service and supply furnished.

deductible — the amount of expense a beneficiary must first meet before Medicare begins payment for covered services.

health maintenance organization (HMO) — an organization that provides a full range of health care coverage in exchange for a monthly fixed fee. HMOs with Medicare contracts offer Medicare beneficiaries all services covered by fee-for-service Medicare. Medicare pays the organizations on a monthly basis for each Medicare beneficiary. Medicare beneficiaries get all Medicare-covered hospital and medical insurance benefits through the organizations. The HMO may also collect a premium from each Medicare member enrolled in the plan.

home health agency — a public or private organization that specializes in giving skilled nursing services and other therapeutic services such as physical therapy in a beneficiary's home.

hospice — a program operated by a public agency or private organization primarily providing pain relief, symptom management, and supportive services for terminally ill people and their families.

hospital insurance — the part of Medicare that helps pay for inpatient hospital care, some inpatient care in a skilled nursing facility, home health care, and hospice care.

intermediary — a private insurance organization under contract to the Federal government to handle Medicare payment for services by hospitals, skilled nursing facilities, hospices, outpatient rehabilitation providers and home health agencies.

medical insurance — the part of Medicare that helps pay for medically necessary doctors' services, outpatient hospital services, and a number of other medical services and supplies not covered by the hospital insurance part of Medicare, as well as some home health services.

medigap policy — private health insurance designed to supplement Medicare.

outpatient facility — a facility designed to provide health and medical services to individuals who are not inpatients.

participating physician or supplier — a physician or supplier who agrees to accept assignment on all Medicare claims.

peer review organizations (PROs) — groups of practicing doctors and other health care professionals under contract to the Federal government to review the care provided to Medicare patients.

prepayment health care plans — health care providers such as Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs). Medicare pays these plans on a monthly basis for each Medicare beneficiary. Medicare beneficiaries get all Medicare-covered hospital and medical insurance benefits through the plan.

prevailing charge — based upon the customary charges for covered medical insurance services or items, the prevailing charge is the maximum charge Medicare can approve for any item or service.

prospective payment system — a process started in 1983 under which hospitals are paid fixed amounts based on the principal diagnosis for each Medicare hospital stay.

quality review organizations (QROs) — groups of practicing doctors and other health care professionals under contract to the Federal government to review the care provided to Medicare patients enrolled in HMOs and CMPs.

reasonable charges — amounts approved by the Medicare carrier which will be either the customary charge, the prevailing charge, or the actual charge, whichever is the lowest.

routine physical examinations — physical checkups or X-ray, laboratory, or other tests made in the absence of definite symptoms of disease or injury.

rural health clinic — a specially qualifed outpatient facility located in an area designated as rural, where there is a shortage of health care service or medical professionals.

skilled nursing facility — a specially qualified facility with the staff and equipment to provide skilled nursing care or rehabilitation services and other related health services.

supplemental health insurance — also called "Medigap" insurance — private health insurance designed to fill some of the gaps in Medicare.

OTHER PUBLICATIONS AVAILABLE ABOUT MEDICARE

Guide to Health Insurance for People with Medicare (512W)
Discusses what Medicare pays and does not pay, types of private health insurance to supplement Medicare and hints on shopping for private health insurance. (HCFA-02110)
NOTE: Free copies of this publication are limited.

Hospice Benefits Under Medicare (513W)
Describes the scope of medical and support services available to Medicare beneficiaries with terminal illnesses. (HCFA-02154)

Medicare and Prepayment Plans (515W)
Describes the health services available to beneficiaries from Medicare-certified HMOs and CMPs. (HCFA-02143)

Getting a Second Opinion (545W)
Explains the importance of getting a second opinion for non-emergency surgery, Medicare coverage of costs, and gives a toll-free number for locating specialists in your area. (HCFA-02114)

Medicare and Employer Health Plans (602V)
Explains the law which requires employers to offer employees age 65 and older the same health insurance they offer their younger employees. (HCFA-02150)

Medicare Coverage of Kidney Dialysis and Kidney Transplant Services: A Supplement to Your Medicare Handbook (603V)
Describes Medicare benefits for people with chronic kidney disease. (HCFA-10128)

To order a copy of one or more of these free publications, fill out and mail the order form at the bottom of the page to:

Consumer Information Center
Department 59
Pueblo, CO 81009

Supplies may be limited. Allow 6 to 8 weeks for delivery.

cut and mail

Check the booklets you want, fill in your name and address and send this order form to: Consumer Information Center, Department 59, Pueblo, CO 81009

- ☐ Guide to Health Insurance for People with Medicare (512W)
- ☐ Hospice Benefits Under Medicare (513W)
- ☐ Medicare and Prepayment Plans (515W)
- ☐ Getting a Second Opinion (545W)
- ☐ Medicare and Employer Health Plans (602V)
- ☐ Medicare Coverage of Kidney Dialysis and Kidney Transplant Services (603V)

Name: _____

Address _____

City _____ State ___ Zip ____

CMS LIBRARY
3 8095 00010861 9

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
6325 SECURITY BOULEVARD
BALTIMORE, MARYLAND 21207

Official Business
Penalty for Private use, $300

Publication No. HCFA 10050
1990